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★ ★ ★

NEW BOOK

Orr's Operative Surgery

Just off press! Never more than right now has the medical profession been in need of the information contained in this new book It is a book that deals solely with the *operations of general surgery* and is intended not alone for the surgeon but for the general practitioner and specialist, too. whether he be in military service or in civilian practice. It is important in both fields because many doctors today are doing surgery who did not before specialize in it, and many new technics have been developed as the result of the war and these are reflected in this book.

Dr. Thomas G Orr's "Operations of General Surgery" is a one-volume encyclopedia of tested and successful technics for operations on the entire body. Moreover, it is much more than just a book on technic because it includes a description of surgical anatomy, surgical indications, and a most important feature—*dangers and safeguards.*

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The book in every respect tells the reader just *what* should be done and exactly *how* to do it.

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ENDEMIC EXUDATIVE PHARYNGITIS AND TONSILLITIS

ETIOLOGY AND CLINICAL CHARACTERISTICS

COMMISSION ON ACUTE RESPIRATORY DISEASES

During the course of studies at the Regional Hospital at Fort Bragg, it was noted that approximately 10 per cent of all patients admitted for respiratory disease had exudate in the pharynx or on the tonsillar tissue. Some of these patients exhibited both clinical and bacteriologic evidence of beta-hemolytic streptococcus pharyngitis; some had beta-hemolytic streptococci in their throats but the clinical picture was not characteristic, and others had neither clinical nor laboratory evidence of beta-hemolytic streptococcus infection. These findings were at variance with commonly held beliefs that the beta-hemolytic streptococcus is the commonest cause of exudative pharyngitis and tonsillitis and that a characteristic clinical picture is associated with the presence of exudate in the throat.[1] It therefore seemed of importance to undertake a systematic clinical and laboratory study of the problem. Since beta-hemolytic streptococci may be harbored in the throats of healthy persons as well as in those suffering from colds and other types of respiratory illness, the diagnosis of streptococcic pharyngitis rests secure only when a specific antibody response to the organism can be demonstrated during convalescence.

One hundred and sixteen cases of exudative tonsillitis and pharyngitis were studied. In 25 per cent of the cases, beta-hemolytic streptococci were found and a rise in streptococcus antibodies was demonstrated in the serums in convalescence. In these cases beta-hemolytic streptococci clearly contributed to, or were responsible for, the clinical condition. In another 25 per cent of cases beta-hemolytic streptococci were found but a rise in antibodies did not occur. In most of these cases there was considerable doubt as to the etiologic significance of the organism. In slightly more than 50 per cent of all cases streptococci were not found on repeated cultures, and in these cases there was little evidence that bacteria were etiologic agents.

Well defined clinical differences were demonstrated between those patients who harbored streptococci and developed antibodies and the other two groups of patients. The latter two groups were, in general, similar to each other in clinical characteristics.

MATERIALS AND METHODS

Source of Cases.—The study was confined to patients who were admitted from selected organizations to the Regional Hospital at Fort Bragg during a ten week period from April to June 1943. The criterion employed for deciding when a soldier required hospitalization was, in general, a temperature of 100 F. (oral) or higher at the time of reporting to the dispensary. Altogether, 900 soldiers from the selected organizations were admitted to the hospital for respiratory symptoms during the period of the study.

The patients were examined within a few hours after admission, and all who had exudate in their throats at that time were included in the study. The presence of exudate at the time of initial examination was the sole criterion for the selection of cases.

Clinical Methods.—The history and physical findings were elicited and recorded in a uniform manner. An attempt was made to date the onset of the illness accurately, to elicit the symptoms and physical signs every day, and to grade their severity.

Codeine was given for symptomatic relief in doses not exceeding one-half grain (0.032 Gm.), but antipyretic drugs were not used. Sulfonamide drugs were administered to a few patients according to clinical indications. Blood samples were obtained on all patients at the time of initial examination and again at approximately four weeks after the onset of illness. Total and differential leukocyte counts were made routinely soon after admission to the hospital, and subsequently as often as indicated.

Bacteriologic and Serologic Procedures.—Swab cultures of the throat were made daily for three successive days, beginning at the time of the first examination of the patient. An effort was made to include in the swabbing the surface of both tonsils or tonsillar fossae, the posterior pharynx and especially surfaces containing exudate. Cultures of the nose and nasopharynx were not taken.

From the Respiratory Diseases Commission Laboratory, Regional Hospital, Section 2, Fort Bragg, North Carolina.

The Commission was assisted by the technical staff of the laboratory, consisting of Marguerite Buckingham, Walter A. Mickle Jr., 2d Lieutenant, Sn. C., Barbara A. Mulliken, Thomas J. Oliver, 1st Lieutenant, Sn. C., Ralph L. Robinson, 1st Lieutenant, Sn. C., and Edith E. Searles.

Members of the Commission on Acute Respiratory Diseases are J. H. Dingle, Major, M. C., A. U. S., Director; T. J. Abernethy, Major, M. C., A. U. S.; G. F. Badger, Captain, M. C., A. U. S.; J. W. Beard, M.D.; N. L. Cressy, Major, M. C., A. U. S.; A. E. Feller, M.D.; A. D. Langmuir, Captain, M. C., A. U. S.; C. H. Rammelkamp, M.D., and E. Strauss, Captain, M. C., A. U. S.

This investigation was supported through the Commission on Acute Respiratory Diseases, Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, Preventive Medicine Service, Office of the Surgeon General, United States Army, and by grants from the Commonwealth Fund, the W. K. Kellogg Foundation, the John and Mary R. Markle Foundation and the International Health Division of the Rockefeller Foundation to the Board for the Investigation and Control of Influenza and Other Epidemic Diseases for the Commission on Acute Respiratory Diseases.

The following officers and their staffs at Fort Bragg assisted the Commission on Acute Respiratory Diseases and made this study possible: Major Gen. D. C. Cubbison, commanding general, Field Artillery Replacement Training Center; Brig. Gen. H. C. Coburn Jr., M. C., surgeon, Fort Bragg; Col. G. D. Chunn, M. C., commanding officer, Regional Hospital; Lieut. Col. W. B. Daniels, M. C., chief of medical services; Lieut. Col. H. O. Brown, M. C., chief of x-ray services; Lieut. Col. F. J. Pohle, M. C., chief of laboratory services; Major R. L. Siegel, M. C., surgeon, Field Artillery Replacement Training Center; Capt. A. H. Green Jr., M. C., admitting officer, Regional Hospital; Capt. H. E. McConnell, assistant admitting officer, Regional Hospital, and the following ward surgeons: Major T. T. Jones, M. C., Capt. R. D. Patterson, M. C., Capt. W. S. Branning, M. C., Capt. C. L. Royster, M. C., and 1st Lieut. L. Chunn, M. C.

1. Felty, A. R., and Hodges, A. B.: Bull. Johns Hopkins Hosp. **34**: 330, 1923. Bloomfield and Felty.[13]

Throat swabs were placed immediately in 3 cc. of broth or isotonic solution of three chlorides and returned to the laboratory, where the swabs were rotated mechanically or by hand in order to obtain mixing of the contents. A loopful of this material was then streaked by a uniform technic on the surface of a freshly made meat infusion agar plate containing 5 per cent horse blood. After twenty-four hours' incubation at 37 C., the plates were examined for beta-hemolytic streptococci and other organisms; the relative numbers of each kind of organism were estimated and a note made as to which organism, if any, was predominant. An organism was considered predominant if it constituted more than 50 per cent of all the colonies (of any kind) on the plate.

Grouping of beta-hemolytic streptococci was performed by the capillary tube precipitin technic, using commercial rabbit serums and bacterial extracts prepared by Fuller's method.[2] Typing was done by the capillary tube modification of the Lancefield method, using bacterial extracts prepared by Lancefield's method.[3] Type specific rabbit serums [4] as well as capillary tubes and serum containers were supplied through the generosity of Drs. Homer T. Swift and Rebecca C. Lancefield.

TABLE 1.—*Distribution of Beta-Hemolytic Streptococci in Three Successive Daily Throat Cultures in 116 Cases of Exudative Tonsillitis and/or Pharyngitis According to the Presence or Absence of Streptococcus Antibodies*

Culture Number *	Antibody		No Antibody		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
A B C	19	68	14	50	33	59
A B	3	11	..	..	3	5
B C	2	7	2	7	4	7
A C	2	7	2	7	4	7
A	..	..	3	11	3	5
B	..	..	2	7	2	4
C	2	7	5	18	7	12
Total	28	100	28	100	56	100

* A, B and C indicate first, second and third cultures respectively.

The streptolysin O used in this study was prepared and kindly supplied by Dr. T. Duckett Jones. The test was a modification of the method of Hodge and Swift.[5] The titers of acute and convalescent serums were determined simultaneously, and all tests were performed with the same lot of streptolysin. The titers were expressed as the reciprocals of the highest serum dilutions which neutralized completely 1 unit of streptolysin.

RESULTS

The 116 cases of exudative pharyngitis and tonsillitis could be classified into three groups on the basis of laboratory findings. When such a division was made, definite clinical differences among the groups were demonstrated.

Beta-hemolytic streptococci were found in one or more of three throat cultures in 56 (48 per cent) of the cases in this series (table 1). Of these 56 cases 76 per cent were positive in the first culture, 88 per cent in the first or second culture and 12 per cent only in the third culture. This would indicate that a single throat culture yielded only reasonably complete information and that the frequency of positive cultures was increased by repeated swabbing.

Distribution of Beta-Hemolytic Streptococci by Groups and Types.—The beta-hemolytic streptococci isolated from 47 of the 56 cases were found to belong to group A. In 1 case the streptococci were members of group B, in 2 cases group C and in 1 case group H. In 5 cases the organisms isolated were not grouped.

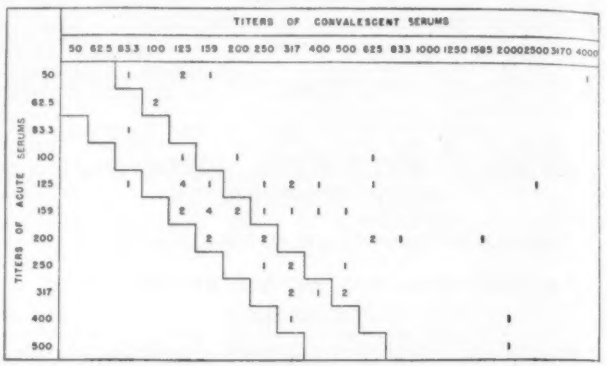

Chart 1.—Antistreptolysin titers of acute and convalescent serums in 55 cases of exudative tonsillitis and/or pharyngitis in which beta-hemolytic streptococci were isolated. In 1 other patient who had streptococci in the throat, convalescent serum was not obtained. Titers are expressed as units of antistreptolysin per cubic millimeter of serum. Figures refer to number of cases. Area within diagonal lines represents changes between acute and convalescent serums considered not significant, i. e. less than two tube change in titer. Figures to right of diagonal area represent significant increases in titer in convalescent serums; figure to left, significant decrease in titer.

Typing was accomplished successfully in 38 of the 47 cases with group A strains; 9 had strains which were not typed with the serums available. The type distribution was as follows: type 3, 6 cases; type 5, 4 cases; type 19, 9 cases; type 26, 4 cases; types 12, 33 and 45, 2 cases each; and types 6, 9, 18, 32, 39 and 44, 1 case each. In addition, three cross reactions which could not be separated further, namely 33 and 26, 17 and 26, and 19 and 33, were each encountered once.

Antistreptolysins.—The antistreptolysin levels of acute and convalescent serums are shown in chart 1 for patients with beta-hemolytic streptococci and, for patients without streptococci, in chart 2. As the test was performed, a two tube change in titer may be considered as beyond the limit of technical error.[6] A rise in titer of two tubes or more was arbitrarily considered to indicate a significant increase in antibodies.

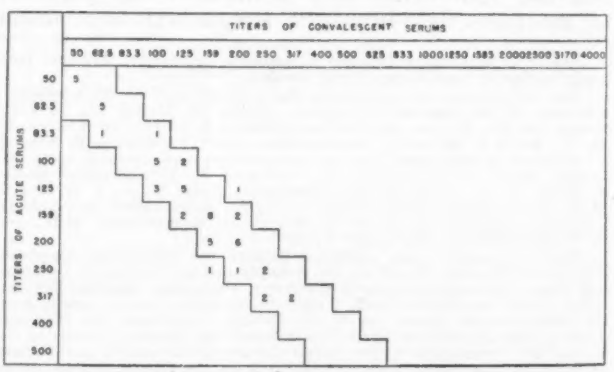

Chart 2.—Antistreptolysin titers of acute and convalescent serums in 60 cases of exudative tonsillitis and/or pharyngitis in which beta-hemolytic streptococci were not isolated. See explanation in legend of chart 1.

2. Fuller, A. T.: Brit. J. Exper Path. **19**: 130, 1938.
3. Swift, H. F.; Wilson, A. T., and Lancefield, R. C.: J. Exper. Med. **78**: 127, 1943.
4. Typing serums were available for types 1, 2, 3, 4, 5, 6, 9, 12, 13, 14, 15, 17, 18, 19, 23, 26, 28, 29, 30, 31, 32, 33, 36, 37, 39, 41, 43, 44, 45 and 46.
5. Hodge, B. E., and Swift, H. F.: J. Exper. Med. **58**: 277, 1933.
6. Mote, J. R., and Jones, T. D.: J. Immunol. **41**: 61, 1941.

Of the 56 patients who harbored beta-hemolytic streptococci, 28, or 50 per cent, developed a rise in antistreptolysin titer of two tubes or more. Of the 60 patients who had no beta-hemolytic streptococci in any of the three throat cultures taken, only 1 showed a similar rise in titer. In this instance there was strong circumstantial evidence that the patient contracted a streptococcic infection after he passed from observation in the hospital and before the second blood specimen was obtained. The almost complete consistency with which an antibody response was demonstrated only in patients in whom beta-hemolytic streptococci were found may be considered evidence of the validity of the cultural methods.

The average interval between onset of illness and the time of convalescent bleeding was four weeks, and this interval was the same for those who did and for those who did not show a rise in antibodies. In 22 of 28 patients the rise was three tubes or more, and in 18 patients the rise was four tubes or more. There were 2 instances of a two tube fall in titer between acute and convalescent serums. While these changes were probably significant, they were most likely due to an infection with beta-hemolytic streptococci that occurred prior to the present illness.

A considerably greater proportion of the cases with streptococci showed a one tube rise in antistreptolysin than was evident in the nonstreptococcus cases. It is entirely reasonable that some of the cases which were regarded as having no antibody response actually had a response which differed only quantitatively from that of the group which was considered to have a significant rise in antibodies. Other evidence of a clinical nature will be presented which tends to bear out the assumption that some of the cases which had no significant antibody response were otherwise similar to those cases which did. The majority of cases in this category, however, closely resembled those of nonstreptococcic sore throat.

The range of antistreptolysin titers which are regarded as normal is variable. It is generally considered, however, that a titer of 250 units or more is elevated, while a titer lower than this is normal.[7] When only a single serum is available from each patient, such criteria must be used; but when both acute and convalescent serums are available it seems more reasonable to record a change in titer. It can be seen in chart 1 that 7 patients whose titer of antistreptolysin in the convalescent serums was less than 250 had a rise of two tubes or more when compared with the levels of their acute serums; in 3 patients the convalescent titer was 100 or less. If only convalescent serums had been available, none of these patients would be considered as having developed antibodies. When these titers were compared with those of the acute phase serums, however, a change was shown which was believed to be significant.

In 2 cases in which only group C beta-hemolytic streptococci were isolated a significant rise in antistreptolysin titer developed. In all the other cases in which a two tube rise was demonstrated, group A strains were isolated from the throat cultures.

Relation of the Number of Organisms to Development of Antibodies.—Of 56 cases with beta-hemolytic streptococci, the organisms were present in predominance in 21 (table 2). When the cases were divided according to whether or not there was a demonstrable rise in antistreptolysin titer of the serums, it was found that in more than two thirds of the cases in which streptococci predominated antibodies developed, while in two thirds of the cases in which streptococci were present but not predominant antibodies did not develop. The figures indicated that antibodies were more likely to develop in those cases in which streptococci were numerous, but it was also evident that a considerable number of cases in which streptococci were not numerous might still respond to the antigenic stimulation of the organisms.

Similar conclusions were reached from the data presented in table 1. This table shows that antibodies developed more frequently in those cases in which two or more throat cultures contained beta-hemolytic streptococci than in cases in which the organisms were isolated in only one of three throat cultures. Whereas streptococci were present in two or more throat cultures in 93 per cent of the cases in which antibodies were present, streptococci were isolated from two or more cultures in only 64 per cent of the cases in which antibodies did not develop. This may be considered as further evidence that the organisms present in many of the cases in the latter group were transient and not intimately related to the clinical disease.

TABLE 2.—*Relation of the Number of Beta-Hemolytic Streptococci in One or More of Three Throat Cultures to the Development of Antibodies*

No. of Organisms	No. of Cases With Antibody Rise	No. of Cases Without Antibody Rise	Total
Present (not predominant)	13	22	35
Predominant	15	6	21
Total	28	28	56

Other Laboratory Studies.—The results of other bacteriologic and serologic studies yielded information chiefly of negative value. In addition to beta-hemolytic streptococci, Haemophilus influenzae, Haemophilus haemolyticus, Staphylococcus aureus and pneumococci were found with the same frequency as in normal throats.[8] The pneumococci were of the "carrier" types that are characteristic of normal persons.[9] Pneumococcus agglutinins which could be considered significant were found in the serum of only 1 of 20 patients who harbored these organisms.

CLINICAL OBSERVATIONS

In the total series of 116 cases of exudative tonsillitis and/or pharyngitis the additional diagnosis of measles was made in 3 cases and of scarlet fever in 5 cases. There were also 14 cases in which clinical and roentgenographic evidence of pulmonary infiltration developed. With the exception of the latter, most patients had a short febrile course and a rapid recovery. Blood cultures were taken on 19 of the most severely ill patients; in all instances they were sterile. Complications were rare; 3 patients had peritonsillar cellulitis

7. Longcope, W. T.: J. Clin. Investigation **15**: 269, 1936. Todd, E. W.: Brit. J. Exper. Path. **13**: 248, 1932. Myers, W. K., and Keefer, C. S.: J. Clin. Investigation **13**: 155, 1934.

8. Dingle, J. H.; Abernethy, T. J.; Badger, G. F.; Buddingh, G. J.; Feller, A. E.; Langmuir, A. D.; Ruegsegger, J. M., and Wood, W. B., Jr.: Am. J. Hyg. **39**: 67, 197 and 269, 1944. Straker, E.; Hill, A. B., and Lovell, R.: A Study of the Nasopharyngeal Bacterial Flora of Different Groups of Persons Observed in London and South-East England During the Years 1930 to 1937, Ministry of Health, Reports on Public Health and Medical Subjects No. 90, London, His Majesty's Stationery Office, 1939.

9. Finland, M.: Medicine **21**: 307, 1942.

but none required surgical drainage, and 1 patient developed suppurative otitis media. None of the patients showed the clinical characteristics of Vincent's angina.

Constitutional Symptoms.—In chart 3 are shown the time of onset of specified constitutional symptoms in

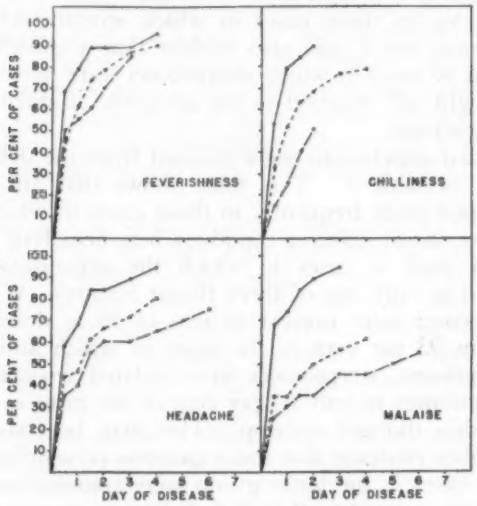

Chart 3.—Onset of specified symptoms. Cumulative frequency by day of disease. Solid lines represent cases of beta-hemolytic streptococci in which antibodies developed; broken lines, cases of beta-hemolytic streptococci in which antibodies did not develop; dotted lines, cases in which there were no beta-hemolytic streptococci. Same symbols used in subsequent charts.

relation to the onset of the disease. These graphs indicate the cumulative frequency of each symptom in relation to the total number of cases in each group included in the analysis. The relationship of the curves of the three groups to one another remained fairly constant for each symptom. It will be seen that, in every instance, symptoms developed more rapidly and occurred in a greater proportion of patients in the group who developed streptococcus antibodies than in

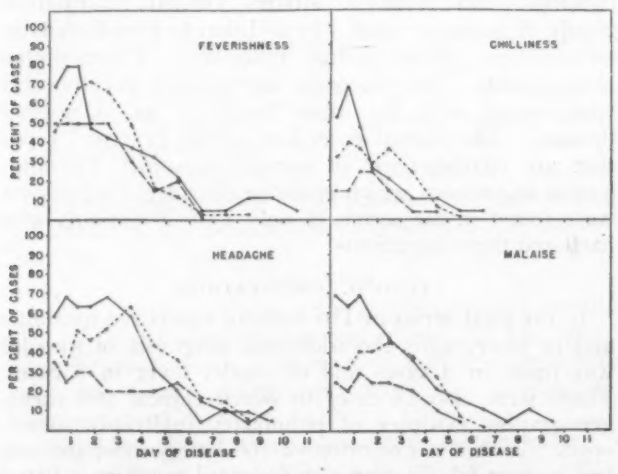

Chart 4.—Frequency of specified symptoms by day of disease. The following rules were used in calculating the percentage frequencies in charts 4, 5, 6 and 7: 1. Patients discharged from the hospital with a specified symptom or sign not present were considered to remain free from that symptom or sign thereafter. 2. Late in the course of illness patients were frequently discharged with a symptom or sign still present. Points were not plotted when this fact made the indicated relationships inaccurate.

the group without streptococci, or with streptococci but without antibodies. The last two groups seemed to be more nearly alike and to be quite distinct from the first.

In chart 4 are depicted the frequencies with which individual symptoms occurred in proportion to the total number of cases in each group by twelve and twenty-four hour periods throughout the disease. Here again there was a rather consistent pattern in each of the three groups, and the relationship of the curves to each other remained the same for each symptom. In the group of streptococcic cases in which antibodies developed, the maximum frequency of symptoms occurred within twenty-four hours of the onset of the disease, while in the other two groups, particularly in the cases in which streptococci were not present, the maximum frequency of symptoms occurred later in the illness.

Localizing Symptoms.—The frequency with which specified localizing symptoms occurred in proportion to the total number of cases in each group by twelve and twenty-four hour periods from the onset of illness is shown in chart 5. As would be expected, soreness of the throat was present in the great majority of cases. It occurred with maximum frequency earlier (within twenty-four hours) in the group of cases with antibodies than in either of the other two groups.

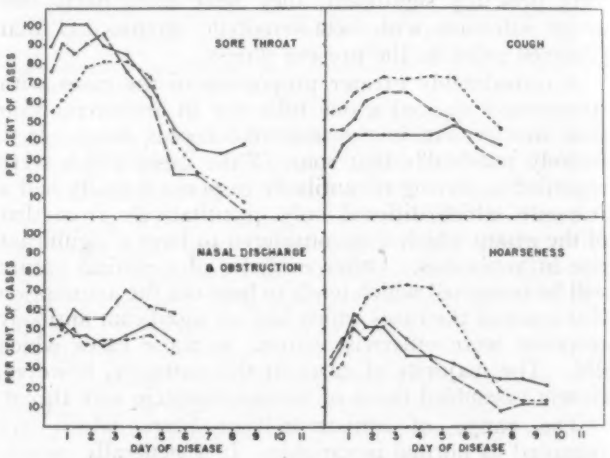

Chart 5.—Frequency of specified symptoms by day of disease.

Cough and hoarseness showed a frequency distribution quite different from soreness of the throat. These two symptoms are not ordinarily considered as essential features of streptococcic sore throat, and although they occurred in about half of the cases in the group they were much more frequent in the cases in which streptococci were not present. The latter group of cases resembled undifferentiated respiratory disease in many ways. The tendency toward more diffuse involvement of the respiratory tract, as indicated by the frequency of cough and hoarseness and the lesser frequency of soreness of the throat, may be considered evidence in favor of this point of view.

Physical Signs.—The important physical signs present in the throat are depicted in charts 6 and 7, which show the frequency of a given sign in relation to the total number of cases in each group under observation on each day, beginning with the second day of disease. In the over all daily frequency of various signs there were no significant differences among the three groups of cases, but, when total frequency was compared with the frequency of severe or intense signs, significant differences became apparent. For example, injection of the tonsils or of the soft palate occurred with equal frequency in all three groups of cases. Diffuse injection of these tissues, however, was twice as frequent

in the cases in which streptococci and antibodies were present as in the other two groups of cases. Similar differences in severity were shown in regard to edema of the uvula, exudate on the tonsils and injection of the pharynx. In general, all of these physical signs were most frequent at the time of the first examination.

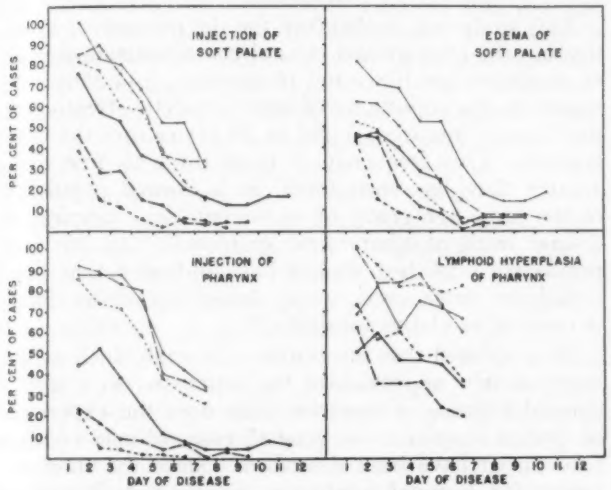

Chart 6.—Frequency of specified physical signs by day of disease. Light lines represent total frequencies; heavy lines, frequencies of pronounced or severe degrees of specified physical signs.

There was but little evidence that new signs appeared in the throat or that signs progressed in intensity after the second day of illness. In contrast to the other physical signs in the throat, the presence of hyperplastic lymph follicles in the pharynx was more common in pharyngitis not associated with beta-hemolytic streptococci than in cases associated with streptococci. It has been noted that hyperplastic lymph follicles on the posterior pharyngeal wall are commonly found in cases of undifferentiated respiratory disease and atypical pneumonia. It was also noted that hyperplastic lymph follicles were more prominent and more common in patients who had no tonsillar tissue than in those who had.

The clinical impressions made at the time the patients were seen in the hospital were compared with the final diagnoses arrived at on the basis of bacteriologic and serologic evidence. Without prior knowledge of

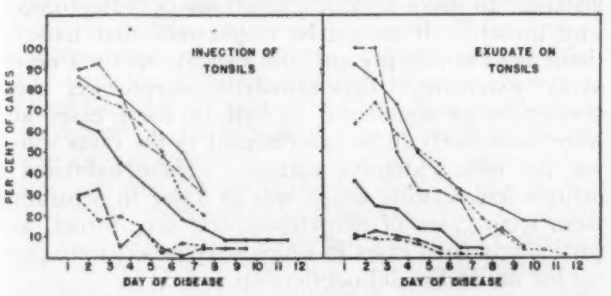

Chart 7.—Frequency of specified physical signs by day of disease. Based on number of patients who had tonsils or tonsillar tags. See symbols in chart 6.

laboratory results, the examiners attempted to predict whether or not beta-hemolytic streptococci would be found in each case. In the 60 cases in which no streptococci were found, the clinical prediction was correct in 50 cases and equivocal in 6, while only 4 cases were erroneously considered instances of "streptococcic sore throat." It was evident that the clinical picture of nonstreptococcic sore throat was usually quite easily distinguished from that of streptococcic sore throat. There was likewise no difficulty in recognizing the fact that cases in which streptococci were present but no antibody rise developed did not present the physical findings of "streptococcic sore throat." Only 15 per cent of the cases in this group were mistakenly considered instances of the latter. On the other hand, the clinical prediction of "streptococcic sore throat" was made correctly in only two thirds of the patients who developed streptococcus antibodies and was considered possible in an additional 15 per cent of such patients, while in 20 per cent it was thought most unlikely that streptococci were present.

Leukocyte Count and Maximum Temperature.—The cases in which streptococcus antibodies developed had a total leukocyte count which averaged 16,000 on the first or second day of disease, while for the other two groups of cases the average initial white count at the same time was 9,000. After the fourth day of illness there were no significant differences in any of the

TABLE 3.—*Relationship of the Number of Beta-Hemolytic Streptococci Present in One or More of Three Throat Cultures to the Maximum Amount of Exudate Observed During Hospital Course in 116 Cases of Exudative Tonsillitis and/or Pharyngitis*

	Amount of Exudate					
	Pinpoint		Discrete		Confluent	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Beta-hemolytic streptococci...	16	33	24	55	16	70
Present (not predominant)	11	23	17	39	7	31
Predominant.....	5	10	7	16	9	39
No beta-hemolytic streptococci	33	67	20	45	7	30
Total.....	49	100	44	100	23	100

three groups. The same relationships held for total polymorphonuclear leukocyte determinations and for the percentage of polymorphonuclear leukocytes. When streptococci were present but did not stimulate an antibody response, they likewise did not produce an elevation of the total or polymorphonuclear leukocyte count.

Little difference was found in the average maximum temperature on each day of disease among the three groups of cases.

Correlation of Presence of Tonsillar Tissue and Extent of Exudate with Presence of Streptococci and Development of Streptococcus Antibodies.—It is a common impression that streptococcic sore throat is more likely to occur in persons who have tonsils than in those who have had a tonsillectomy.[10] In this study beta-hemolytic streptococci were found with equal frequency in those patients who had no tonsillar tissue and in those who had tonsils or tonsillar tags. Moreover, streptococcus antibodies developed with equal frequency in the two groups of cases.

A correlation was demonstrated between the amount of exudate in the throat and the presence and numbers of beta-hemolytic streptococci (table 3). Two thirds of the cases in which the exudate consisted of tiny flecks (pinpoint) did not exhibit beta-hemolytic streptococci, and in less than one third of those cases of pinpoint exudate in which streptococci were present were they predominant. However, 70 per cent of the

10. Bloomfield, A. L., and Felty, A. R.: Definition of Hemolytic Streptococcus Parasitism in Upper Air Passages of Healthy People, Arch. Int. Med. **32**: 386 (Sept.) 1923. Bloomfield and Felty.[12] Finland.[9]

cases in which the exudate was extensive and confluent showed the presence of streptococci, and of these more than half had the organisms present in predominance. Similarly, streptococcus antibodies developed more frequently in cases with large amounts of exudate than in cases with small amounts of exudate. It was apparent that while exudate in the throat may be associated with or caused by agents other than beta-hemolytic streptococci, extensive exudate was more likely to be associated with the presence of large numbers of these organisms, capable of stimulating the formation of antistreptococcus antibodies. In the absence of streptococci, exudate tended to be pinpoint or small in extent.

Relation of Types of Beta-Hemolytic Streptococci to Clinical and Immunologic Response.—A comparison of all cases in which the same type of group A strain was isolated revealed a number of interesting points (table 4). In all the 6 cases in which type 3 was found, antistreptolysins developed in high titer. Moreover, in 5 of the 6 cases the clinical diagnosis was scarlet fever or a severe streptococcic sore throat. It was evident that the type 3 organism was rather virulent and invasive and capable of stimulating antibody formation. To a lesser extent the behavior of the type 5 organisms appeared to be somewhat like that of the type 3 strains. On the other hand, the type 19 organism, which was found in 9 cases, seemed to be lacking in virulent or invasive qualities, since only 1 patient infected with this type of beta-hemolytic streptococcus had a clinically recognizable "streptococcic sore throat," and only 3 of the 9 patients developed a rise in antibodies. The type 26 organisms were of interest, since 5 of the 6 patients infected with this organism were admitted from one battery of 250 men. This was the only instance of focal concentration of cases noted in the study. The patients were admitted to the hospital over a period of six weeks and had, in general, mild but clinically recognizable streptococcic infections. The organism was apparently not especially potent in stimulating an antibody response.

TABLE 4.—*Immunologic Response, Clinical Diagnosis and Distribution of Cases According to Types of Group A Beta-Hemolytic Streptococci Isolated*

Type of Group A Beta-Hemolytic Streptococcus	Case Number	Anti-Streptolysin Change *	Clinical Diagnosis
3	34	9	Streptococcic sore throat, severe
	41	3	Streptococcic sore throat, severe
	70	13	Peritonsillar cellulitis
	74	6	Mild nonstreptococcic sore throat
	75	5	Scarlet fever
	79	20	Scarlet fever
5	29	4	Streptococcic sore throat, moderate
	42	7	Streptococcic sore throat, mild, and atypical pneumonia
	61	4	Streptococcic sore throat
	90	0	Nonstreptococcic sore throat and atypical pneumonia
19	15	0	Nonstreptococcic sore throat
	32	0	Nonstreptococcic sore throat
	35	3	Nonstreptococcic sore throat
	40	0	Nonstreptococcic sore throat and atypical pneumonia
	43	2	Nonstreptococcic sore throat
	58	2	Peritonsillar cellulitis
	59	0	Nonstreptococcic sore throat
	64	0	Nonstreptococcic sore throat
	83	0	Chronic hypertrophic tonsillitis
26	18	0	Streptococcic sore throat, mild
	22	0	Streptococcic sore throat, mild
	45	2	Scarlet fever, mild
33, 26	93	0	Streptococcic sore throat, moderately severe
17, 26	110	5	Scarlet fever, severe
	114	0	Nonstreptococcic sore throat

* Number indicates number of tubes increase in titer between acute and convalescent serum.

COMMENT

This study was undertaken for the purpose of investigating the etiology and clinical characteristics of cases of exudative tonsillitis and pharyngitis, especially with regard to the importance of beta-hemolytic streptococci. Such organisms were found in 50 per cent of the cases studied. This frequency is from three to five times greater than has been found in a normal population of the same age group or in patients with respiratory disease without pharyngeal exudate.[11] In contrast, previously published studies have indicated that beta-hemolytic streptococci were almost invariably found in cases of exudative tonsillitis.[12]

It is believed that the results of a study such as this more closely approximate the situations met in the general practice of medicine than does the experience of civilian hospitals. In general, cases of mild endemic sore throat have been described. Since the chief criterion for hospital admission was a temperature of 100 F., most of these cases would not have been hospitalized in civilian life. Epidemic streptococcic sore throat was not encountered in this series.

Streptococcus antibodies developed in 28 of the 56 cases in which streptococci were present. The streptococcus etiology of these cases is regarded as certain, and hence they have been considered in a separate group and their clinical characteristics defined. The onset of this group of cases was more abrupt and, in the great majority, the maximal development of symptoms and physical signs was reached within twenty-four to forty-eight hours. In general, the symptoms were not more severe than those experienced by patients with nonstreptococcic sore throats, but characteristic differences were seen in the local physical signs. Pharyngeal and tonsillar mucosal injection was more intense and more diffuse, the degree of edema was greater and the exudate was more extensive in this group of cases. Wide variations in this pattern were apparent, however, and it seemed impossible in many instances to make a clinical diagnosis of "streptococcic sore throat." It should be emphasized that tonsillar tissue need not be present, and exudate was not necessarily extensive. Beta-hemolytic streptococci were present in predominance in half of these cases and were more likely to be predominant in the cases showing the most extensive exudate. These exhibited a definite leukocytosis which was of value in separating them from cases of nonstreptococcic sore throat, and particularly from cases in which streptococci were present but antibodies did not develop.

In another 25 per cent of cases with exudate in the throat, beta-hemolytic streptococci were found but a significant rise in streptococcus antibodies did not develop during convalescence. It has been pointed out that more cases in this group showed a one tube rise in antistreptolysin titer than was found in the group

11. Unpublished observations by Commission on Acute Respiratory Diseases.

12. Blomfield, A. L., and Felty, A. R.: Bacteriologic Observations on Acute Tonsillitis with Reference to Epidemiology and Susceptibility, Arch. Int. Med. **32**: 483 (Oct.) 1923.

of cases in which streptococci were not present. It is likely, in some instances, that the difference between cases with streptococci with antibodies and without antibodies was quantitative rather than qualitative. Clinically, several cases were encountered which presented characteristic "streptococcic sore throats" and had streptococci in the throat cultures but did not develop a two tube rise in antibodies. It is known that some patients with scarlet fever do not exhibit a rise in antistreptolysin titer during convalescence.[6] There is, therefore, no reason to believe that the "antibody" group was necessarily complete and that all cases in the "nonantibody" group are to be regarded a priori as belonging in a different category. Nevertheless, this separation has been made because there were a sufficient number of distinguishing points between the two groups of cases, such as well defined differences in symptoms and physical signs, in number and persistence of streptococci in the throat, and in total and differential leukocyte counts. In summary, it seems justifiable to conclude that in the majority of the cases without streptococcus antibodies the streptococci were not the primary cause of the exudate in the throat and may have had no more relation to the infection than any of the other bacteria normally present in the throat.

In the 50 per cent of cases in this series in which beta-hemolytic streptococci were not found, the etiology remains unknown. In these cases the illness was generally mild but the onset was rather acute and constitutional symptoms were present in the majority of cases. The pharyngeal and tonsillar exudate was rarely confluent, usually small in extent and most often pinpoint. There was a tendency for cough and hoarseness to develop, indicating perhaps that, whatever the causative agent, it affected a larger area of the respiratory tract than the oropharynx alone. Redness, injection and edema of the mucous membranes were present in the majority of instances but were rarely of severe degree. Prominent hyperplastic lymphoid follicles on the posterior pharynx were seen commonly. This type of sore throat appears to be closely related to the majority of cases of undifferentiated respiratory disease.

SUMMARY

One hundred and sixteen hospital patients having exudate in the pharynx or on the tonsils at the time of initial examination were studied. On the basis of laboratory data the following classification was made: 25 per cent of the patients had beta-hemolytic streptococci and exhibited a rise in titer of streptococcus antibodies during convalescence, 25 per cent of the patients had streptococci but did not develop antibodies, and 50 per cent of the patients had no streptococci. Definite differences were demonstrated between cases with antibodies and those without, in regard to mode and rapidity of onset, total frequency of symptoms, severity of certain physical signs and leukocyte count. Cases with beta-hemolytic streptococci which did not develop antibodies were similar in clinical characteristics to cases which did not exhibit streptococci. It is concluded that in approximately 25 per cent of the cases studied the exudate was caused by beta-hemolytic streptococci, while in 75 per cent of the cases the causative agent was unknown. Except for the presence of exudate, the latter group did not appear to differ from the great majority of cases of undifferentiated respiratory disease.

APLASTIC ANEMIA FOLLOWING TRINITROTOLUENE EXPOSURE

A REPORT OF THREE CASES

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As has been pointed out many times, trinitrotoluene is a toxic material and causes numerous symptoms and signs. Fortunately, the great majority of these are of minor consequence. The most frequent complaint of the handler of trinitrotoluene is a dermatosis. This is generally mild and usually confined to the hands. Next in frequency are gastric complaints with nausea, vomiting, a feeling of fulness and occasionally a rather typical peptic ulcer syndrome. Chest pain, cough and nosebleeds are complained of by relatively fewer workers. There are also two other pathologic changes caused by trinitrotoluene and these are of a much more serious nature. The first and more common of these is hepatitis. The second and much more disastrous result of exposure is aplastic anemia.

It would appear that in certain susceptible persons the bone marrow may be damaged by trinitrotoluene. It is suggested that individual predisposition is of principal importance because of the rare occurrence of this disease in spite of the great many workers exposed to trinitrotoluene in this war and the last. That the degree of susceptibility of the bone marrow is important will also be shown by the occurrence of this phenomenon in three workers whose environments showed a relatively low concentration of the toxic material. These men developed a fatal disease while in trinitrotoluene exposures that varied close to the maximum permissible limit of 1.5 mg. per cubic meter of air. It is also of interest to note that during the time of operation of this particular plant only 1 case of trinitrotoluene hepatitis has occurred.

The English literature has reported a number of cases of fatal aplastic anemia in munitions handlers.[1] The exposure, clinical picture and course have been not unlike those included here.

It is also true that the American munitions industry as a whole is seeing about as many fatal cases of aplastic anemia as of hepatitis. The mortality of this disease among the few cases observed has been high. I am informed that half of the first eight trinitrotoluene fatalities reported in American shell and bomb loading plants during the first 93,000 man-years of operations were cases of aplastic anemia.[2] In other plants, these cases have also occurred in places of relatively low trinitrotoluene concentration. One case of aplastic anemia followed recovery from hepatitis in England,[3] but such a combination has not been seen in this country to my knowledge.

The age, physical characteristics, previous employment and other factors appear to have no bearing on the susceptibility in these cases.

The outstanding factor in these cases would appear to be exposure to trinitrotoluene dust and fumes for a

1. Evans, R. M.: T. N. T. Jaundice, Lancet **2**: 552 (Nov. 8) 1941. Hilton and Swanston.[3]

2. McConnell, W. J., and Flinn, R. H.: Paper read at the eighth annual meeting of the Industrial Hygiene Foundation of America, Inc., in November 1943.

3. Hilton, J., and Swanston, C. N.: Clinical Manifestations of Tetryl and Trinitrotoluene, Brit. M. J. **2**: 509 (Oct. 11) 1941, cited in T. N. T., Lancet **2**: 605 (Nov. 15) 1941.

period of several weeks to several months. From experience gained in England, it has generally been felt that if an employee tolerates trinitrotoluene for as much as five or six months he is unlikely to suffer any dangerous consequences.[3]

It has not been possible to reproduce aplastic anemia in dogs with trinitrotoluene, and it has been incorrectly suggested by myself[4] and others[5] that it was likely that the so-called aplastic anemia was a final stage of the anemia so often seen in trinitrotoluene handlers and was due to blood destruction. That this is not true is well shown by the typical hypoplastic or aplastic appearance of the bone marrow in these cases as well as other recent ones.

In my experience the patient usually presents himself complaining of weakness and easy fatigue. He may state that he noticed a few purple spots and came in because he was curious about them. Sore mouth or respiratory complaints may be the only symptoms. A blood count which should be taken on any trinitrotoluene handler with such complaints will usually give an immediate indication of the severity of the disease. Sternal bone marrow biopsy should be done in cases showing suggestive blood pictures. This procedure will rule out aleukemic leukemia, agranulocytosis and thrombocytopenic purpura, the three most likely confusing conditions. It is not likely that the bone marrow study will be of any prognostic significance in determining the cases of aplastic anemia in which survival will occur with careful treatment. By that I mean that, even though marrow destruction does not appear particularly extensive, death may follow rapidly in spite of frequent transfusions.

Treatment consists primarily in removal from contact with trinitrotoluene and other substances known to depress bone marrow and careful cleansing of the skin to remove traces of the poison. Support with frequent transfusions of fresh blood is of the greatest importance in prolonging life. Other therapeutic aids of somewhat questionable value include pentnucleotide in full doses of 40 cc. daily, crude liver extract, extract of yellow bone marrow, a high vitamin, high caloric diet and scrupulous care of the mouth in hope of preventing infection. The use of concentrated or diluted cells is suggested and was used in 1 case. It solves the problem of obtaining blood if a plasma bank is near. The cells should be not over 24 hours old in order to receive the value of the short lived white cells. This is suggested as there is no lack of plasma in these patients. It is felt that this method should be given a further test.

The prognosis is extremely grave, and most of the cases have run a very short course in spite of intensive treatment.

REPORT OF CASES

CASE 1.—A white man aged 26, who had been employed in the shipping room of a bomb line for several months, reported to the plant hospital on Dec. 15, 1942 complaining of general malaise, aching pains and upper respiratory infection. Unfortunately no blood work was done and the patient was allowed to go home, where his family physician gave him 100 grains (6.5 Gm.) of sulfanilamide over a period of two days. He was also given elixir of phenobarbital and a "cold" capsule. After several days of this treatment he began having a sore mouth, and a dentist was consulted because it was thought that he had "trench mouth." The dentist stated that it was not a Vincent's infection and prescribed a mouth wash. He gradually became worse and was sent to a nearby hospital on Jan. 2, 1943. Shortly after admission a few purpuric spots were noted over the lower extremities. These rapidly increased in number and occurred over the rest of the body. On the third day he had epistaxis, and the following morning he had tarry stools. During the hospital stay he was given several transfusions that resulted in severe reactions. He progressed rapidly downward, developed deep jaundice by the sixth day and died on the seventh. The laboratory findings are summarized in table 1. Autopsy findings of particular interest were confined to the bone marrow, kidneys and liver. Dr. W. R. Mathews, the pathologist, reported: "The sternal bone marrow was brownish red but there was no marrow fluid on the cut surface on pressure of this tissue. Sections from the sternal marrow showed a marked degree of hypoplasia. In fact, for the most part they are devoid of marrow cells and are in an aplastic state. Areas of considerable size show nothing but fat and marked congestion of the sinusoids and capillaries. This last feature accounts for the predominantly red color exhibited by the marrow on gross examination. Both the erythropoietic and the leukopoietic elements are involved. The marrow cells remaining are of the mature or more mature types. . . .

"The liver cells are more granular than normal and some of them are vacuolated. The latter change tends to occur around the central vein, where there is also necrosis. The necrosis is predominantly central but does occur to a less extent in the midzone. . . ."

Dr. Mathews' comment on his findings is pertinent and is quoted in full: "The primary disease in this case was an acute form of aplastic anemia. It is not possible to suggest from these examinations whether this is a primary or secondary form of the disease. I mean, by secondary, anemia due to some agent such as benzol, trinitrotoluol or x-rays. The etiology would have to be established or excluded by history of exposure to one of the agents. It can be said that this patient's clinical features and the autopsy findings are perfectly consistent with the primary form, but, on the other hand, there are no inconsistencies on these bases for the secondary type.

"He developed terminal pneumonia and sepsis which was not unexpected in the presence of almost total disappearance of the granulocytes from the peripheral blood as well as from the marrow. This neutropenia was responsible for the development of the oropharyngeal ulcerations which I understand

TABLE 1.—*Laboratory Reports in Case 1*

Date	R. B. C. in Millions	Hemoglobin, Gm.	W. B. C. in Thousands	Neutrophils, %	Lymphocytes, %	Large Mononuclears, %	Serum Bilirubin, Mg.	Transfusion of Whole Blood, Cc.
1/ 2/43	3.5	8	6.5	5	89	6	...	...
1/ 4/43 (pronounced transfusion reaction)	3.1	7	5.0	28	66	5	...	100
1/ 5/43 (mild transfusion reaction)	2.8	6.5	4.2	15	80	5	...	500
1/ 7/43 (profuse epistaxis)	2.5	6.5	2.4	..	..	..	...	500
1/ 8/43 (patient jaundiced and comatose)	1.9	...	0.7	..	..	..	2.2	500
1/ 9/43 (pronounced melena)	1.4	...	1.8	14	86	..	...	500
1/10/43 (died)	...	...	...	..	..	..	...	500

Medication included pentnucleotide, liver extract and extract of yellow bone marrow.

4. Eddy, J. H.: Some Toxic Reactions of Common Explosives, New Orleans M. & S. J. 95: 511 (May) 1943.
5. Voegtlin, C.; Hooper, C. W., and Johnson, J. M.: Trinitrotoluene Poisoning: Its Nature, Diagnosis and Prevention, Bull. 126, Hyg. Lab., U. S. P. H. S., 1920.

existed and also let the gap down for invasion of the blood stream by perhaps a number of types of bacteria from the mucous surfaces, especially the oropharynx. Bacterial colonies were noted in sections from the lungs, spleen, lymph nodes and liver. The pneumonia was of the type that usually develops in the course of agranulocytosis—the exudate is devoid of polymorphonuclear leukocytes.

this patient had multiple blood transfusions, one has to consider the possibility of a transfusion reaction. Ordinary methods of testing for compatibility of blood to be transfused do not detect the presence of the Rh factor. Assuming that the patient was Rh negative and the donor Rh positive, one would have a set up that might eventuate in a transfusion (hemolytic) reaction. The changes in the kidneys and the focal necroses in

TABLE 2.—*Laboratory Data in Case 2*

Date	Serum Bilirubin, Mg.	R. B. C. in Millions	W. B. C. in Thousands	Polymorphonuclears, %	Small Lymphocytes, %	Platelets	Reticulocytes, %	Hemoglobin, %	Blood Transfusions, Cc.
4/22	0.35	3.5	1.250	19	80	17,000	0.0	68.2	.....
4/23	....	....	.....	..	..	.....	...	....	500
4/24	....	....	.....	..	..	.....	...	....	500
4/25	....	3.09	1.550	20	80	21,000	0.1	....	.....
4/26	....	2.36	850	30	64	.....	..	....	1,000
4/28 (Roentgenogram of chest)	0.32	3.46	250	30	70	.....	0.1	61	.....
4/30	....	3.06	550	..	..	.....	0.0	58.6	.....
5/ 2	....	3.21	900	69	28	.....	0.1	61	500
5/ 5	....	3.05	950	23	75	.....	0.2	56	.....
5/ 7 (excision and drainage of gluteal abscess)	....	3.07	1.050	..	..	.....	0.0	58.6	.....
5/11	....	3.1	2.300	78	20	.....	0.1	....	.....
5/17	....	1.19	3.600	42	55	.....	0.0	24	500
5/24	....	1.68	3.000	69	31	.....	0.2	29	.....
5/30	....	2.05	2.900	50	50	.....	0.5	31	500
6/ 7 (sternal bone marrow biopsy)	....	1.46	2.200	..	..	.....	0.4	26	500
6/12	....	1.58	.....	..	..	.....	...	29	.....
6/14	....	....	.....	..	..	.....	...	....	500
6/24 (second admission)	....	2.01	1.250	..	..	.....	0.4	0.34	1,000
7/ 7 (third admission)	....	2.31	1.350	..	..	.....	0.8	45	500
7/19 (fourth admission; had reaction to blood)	....	....	.....	..	..	.....	...	....	300
7/24 (fifth admission)	....	1.15	.....	..	..	.....	...	18	1,000
8/10 (sixth admission; having gastrointestinal hemorrhages)	....	1.30	.....	..	..	.....	...	26	500
8/18	....	2.33	.....	..	..	.....	...	43	500
8/25	....	2.89	.....	..	..	.....	...	45	500
9/ 1	....	2.55	.....	..	..	.....	...	34	500
9/ 3	....	0.70	.....	..	..	.....	...	16	1,000
9/ 4	....	1.81	.....	..	..	.....	...	35	.....
9/ 5	....	1.39	.....	..	..	.....	...	24	1,500
9/ 7	....	2.77	.....	..	..	.....	...	40	.....
9/10	....	1.30	.....	..	..	.....	...	26	.....
9/15 (seventh admission)	....	1.42	.....	..	..	.....	...	18	1,500
9/18 (eighth admission)	....	1.07	.....	..	..	.....	...	19	1,000
9/20 (ninth admission)	....	....	.....	..	..	.....	...	....	2,000
9/29	....	1.26	.....	..	..	.....	...	22	2,000
10/ 2	....	1.57	.....	..	..	.....	...	21	500
10/ 4 (tenth and final admission)	....	0.65	.....	..	..	.....	...	8	.....

Patient came to hospital in shock and having profuse gastrointestinal hemorrhage. Died on Oct. 4, 1943.

On April 22: stool for occult blood was positive; mean corpuscular volume, 91.1 cubic microns; mean corpuscular hemoglobin, 28.2 micro micrograms; urine for urobilinogen negative; no clot retraction; normal fragility test; Wassermann reaction negative; clotting time 3:30; bleeding time 2:30.

TABLE 3.—*Laboratory Reports in Case 3*

Date	R. B. C. in Millions	Hemoglobin in Gm.	W. B. C. in Thousands	Polymorphonuclears, %	Small Lymphocytes, %	Large Lymphocytes, %	Eosinophils, %	Clot Retraction	Tourniquet Test	Transfusions (Whole Blood), Cc.	Transfusions (Cells Only), Cc.
10/13	3.41	10	3.80	26	65	5	4	No	Pos.	...	.....
10/14	....	....	2.80	35	62	1	2	...	..	750	.....
10/15	3.85	10.7	1.00	46	51	..	3	...	..	900	.....
10/16	4.52	15.2	0.80	24	76	..	..	...	..	500	.....
10/17	4.56	15.5	0.25	12	80	4	4	...	..	...	.....
10/18	4.53	14.8	0.30	17	81	2	..	...	..	500	1,000
10/19	5.11	17.0	0.70	2	80	2	..	...	..	...	.....
10/20	5.33	17.0	0.74	2	84	12	2	...	..	...	.....
10/21 (stopped pentnucleotide, stopped liver extract)	5.21	17.5	0.44	2	94	4	..	...	..	...	1,000
10/21 (buttocks very sore, no abscess)	5.48	18.6	0.54	3	94	..	1	...	..	...	.....
10/22 (passing blood in urine, diarrhea; patient weaker; more petechiae)	5.34	17.5	0.30	2	94	4	..	...	..	500	500
10/23 (melena, ulceration of pharynx; heavy hematuria; patient agglutinating own cells; extreme weakness, wet lungs)	4.48	16.1	0.20	..	..	..	..	...	..	...	.....
Patient died											

R. B. C. normal in appearance. W. B. C. mature. Patient receiving liver extract intramuscularly 2 cc. daily; pentnucleotide 10 cc. intramuscularly daily. Had cleansing bath to remove all trinitrotoluene from skin, checked with skin webster. Sternal bone marrow biopsy showed an aplastic marrow on Oct. 16, 1943.

"The jaundice which developed during the last forty-eight hours of life is, in my opinion, mainly of the hemolytic type. The urine was negative for bilirubin but positive for urobilin and occult blood (benzidine test). Although there were focal necroses in the liver, one would expect some bilirubin in the urine provided the jaundice had been due to toxic hepatitis. A septicemia due to a hemolytic micro-organism (Streptococcus haemolyticus ?) could have caused the jaundice. Also, since the liver could be due to this cause. Of course, it is not possible to say from the sections whether the pigment casts in the renal tubules are hemoglobin or bile (bilirubin). There are no tests that differentiate these in fixed tissue specimens. The histologic changes may be identical in both."

CASE 2.—A white man aged 65 had been employed in a bomb line cooling bay for four months. He developed a respiratory infection in March that seemed of no consequence but lasted

several weeks. He took four Dasin capsules [6] and compound infusion of senna during this time but no other medicine. He did not report this illness and resigned on March 30, 1943. During the first part of April he noted a few purplish spots on his lower extremities. He became weaker and had to go to bed at about that time. On April 21 the patient first reported to the hospital, at which time he was literally covered with purpuric spots and had several large areas of ecchymosis on his buttocks. The blood picture showed depression of all cellular elements, and a diagnosis of aplastic anemia was made. He was referred to a local sanatorium, and table 2 shows a summary of laboratory findings and treatment through his many admissions. A sternal bone marrow biopsy was studied by Dr. W. R. Mathews, who reported findings identical to those in case 1. The patient finally died on October 4, having lived about five months after discovery of his disease. His death was caused by shock precipitated by massive gastrointestinal hemorrhages.

CASE 3.—A white man aged 50 had been engaged in sweeping the floor in a cooling bay of a bomb loading line for about two months. He had been in excellent health. During a period of approximately forty-eight hours prior to reporting to the hospital he had noted that he did not feel quite as well as usual. About twenty-four hours before his appearance at the infirmary he noticed a number of small purplish spots on his lower extremities, and this was the thing that caused him to seek medical advice. When first seen the patient was well developed and well nourished and did not appear acutely ill. He treated his complaints lightly and was anxious to return to his day's work. He appeared more in search of information about himself than seeking treatment. Examination showed several petechiae on the upper extremities, with one or two large areas of subcutaneous hemorrhage in the right elbow region. The tourniquet test was positive. Blood studies revealed moderate depression of all cellular elements of the blood, with the platelet count being definitely reduced. In view of these findings a diagnosis of aplastic anemia seemed likely, and this was later proved by sternal bone marrow biopsy. Details of the study of the marrow were essentially no different than that seen in the first case. The usual therapeutic aids were given, including 3,100 cc. of fresh blood. His total red cell count reached 5,480,000, with 18.6 Gm. of hemoglobin, but his white cell count was never raised as high as 1,000 cells. Besides the fresh whole blood he was also given the cellular element from 2,500 cc. of blood. These cells were from the fresh blood prepared in the plasma bank at Shreveport Charity Hospital and were used within a few hours of preparation. The hospital course is summarized in table 3. His death followed a short episode of what undoubtedly was blood stream invasion.

Unfortunately, autopsies could not be secured in the last 2 cases.

COMMENT

The diagnosis of aplastic anemia in these 3 cases seems to be unquestionable. Case 3 shows a blood picture that may be confused with agranulocytosis, but the presence of purpuric phenomena, a low platelet count and a typical bone marrow picture substantiates the diagnosis of aplastic anemia. It may be well to stress the value of bone marrow biopsy with preparation of stained sections as a diagnostic aid in cases of this type. The incrimination of trinitrotoluene absorption as a cause of the pathologic process may be open to question particularly in the first case, in which 100 grains of sulfanilamide and cold capsules were given prior to a definite picture of aplastic anemia. On the other hand, who can deny that his original symptoms were not those of aplastic anemia? In this particular case I was unwilling to attribute the death to trinitrotoluene, but when 2 more cases developed in the same plant it was felt that a change of outlook was in order. In these cases an investigation of previous employment, use of drugs, recent infections and other possible chemical or x-ray exposure was carefully made. In no case other than that noted was anything detected that appeared to be of importance. That any or all of these cases may be the so-called primary form cannot be denied; but the occurrence of these 3 cases fairly close together would seem to be asking a great deal of coincidence. These men were investigated from the standpoint of adherence of rules regarding change of clothes, bathing and other suggested precautionary measures. Only the first case showed anything of note and that was a failure to take the prescribed daily shower at the end of work. Bathing rules had not been strictly enforced among shipping room workers because it was felt that contamination was negligible.

Periodic examinations had been made on all of these men but had failed to give any warning of the impending disaster. The periodic examination is done by a nurse every three weeks, the findings being then studied by the medical staff. The examination consists, at this plant, of a general inspection with particular attention being paid to the condition of the skin and the color of the mucous membranes. The history regarding appetite, nausea and vomiting, abdominal pain and the sense of well-being is elicited. Following this, a record is made of the pulse, blood pressure and weight. The laboratory examination consists only of a hemoglobin determination. The entire procedure is intended only as a screening process, and suggestive findings call for more thorough investigation or a change in work for the employee. In case 3 the examination revealed nothing of note, with a hemoglobin of 13.5 Gm. only three days prior to hospitalization. That such is possible needs only a glance at the tables for confirmation, as they show a remarkably rapid course.

Test of air contamination in places where these men worked show no demonstrable trinitrotoluene in the shipping room where the first patient worked. The conditions in the cooling or puddling room were not as good, showing trinitrotoluene concentrations of from 1 to 3.5 mg. per cubic meter of air. While some of the samples are higher than the accepted maximum allowable concentration of 1.5 mg. per cubic meter, this is not an environment of considerable contamination as compared to a few other work rooms on a bomb loading line.

Box 1162.

6. Dasin capsules contain acetophenetidin, Dover's powder, atropine sulfate, acetylsalicylic acid, camphor and caffeine.

Medical Progress in Alexandria.—After the death of Erasistratus (300-225 B. C.) there was a lull in medical progress in Alexandria for almost five hundred years. The Greek medical center where the doctrines of Hippocrates and Aristotle were taught became a babel of medical concepts. Personal ambition, jealousy and greed divided the medical profession into many sects, systems and methods of teaching, each of which bore a distinct name. Those that received their main inspiration from the "Father of Medicine" were known as Dogmatists, albeit his methods of scientific investigation were not followed. Those who rejected medical authority and discarded the study of anatomy and physiology came to be known as Empirics. They depended entirely on experience (mainly of their own) as the basis of their therapy of the sick. Their principle was "post hoc, ergo propter hoc," a doctrine which still acts as an incubus in modern therapeutics and a handicap to scientific investigations.—Gordon, Benjamin Lee: The Romance of Medicine, Philadelphia, F. A. Davis Company, 1944.

THE EFFECT OF SODIUM BICARBONATE ON THE SERUM SALICYLATE LEVEL

DURING SALICYLATE THERAPY OF PATIENTS WITH ACUTE RHEUMATIC FEVER

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During a study of massive salicylate therapy in rheumatic fever, a patient who was taking a constant daily amount of sodium salicylate by mouth and was maintaining a fairly constant serum salicylate level asked for sodium bicarbonate to relieve his "gastric discomfort." When this was given it was noted that the serum salicylate level fell decidedly, although the patient continued to receive the same dose of sodium salicylate.

Since it is claimed that plasma salicylate levels of at least 350 micrograms per cubic centimeter are important in the treatment of rheumatic fever [1] and since it is customary to give equal amounts of sodium salicylate and bicarbonate during salicylate therapy, it was thought of importance to investigate the influence of sodium bicarbonate on the serum salicylate level.

METHOD

Daily determinations of blood salicylate levels were made according to the method recently described by Brodie, Udenfriend and Coburn,[2] with the one modification that the determinations were made on serum instead of plasma.[3] In order to minimize the irritant effects of the drug on the gastrointestinal tract, enteric coated tablets of sodium salicylate were used exclusively throughout the work.

Four adult patients with acute rheumatic fever and 2 healthy adults were given sodium salicylate by mouth in doses ranging from 7.2 to 10 Gm. a day. The dose for each individual was kept uniform, and one sixth of the total daily dose was given every four hours day and night. After the serum salicylate level had become fairly stabilized, equal doses of sodium bicarbonate were given orally with each dose of sodium salicylate. Sodium bicarbonate was given for a variable period of time; it was then withdrawn and the patient was maintained for a further period on salicylate alone.

Two other healthy adults were given equal doses of sodium salicylate and sodium bicarbonate from the beginning of the experiment. After five days, sodium bicarbonate was withdrawn and the subjects were maintained for a further period on salicylate alone.

RESULTS

In chart 3 are shown observations made on a patient with acute rheumatic fever. The serum salicylate level during the first twelve days varied between extreme values of 381 micrograms and 558 micrograms per cubic centimeter of serum. Administration of sodium bicarbonate was then begun. Twenty-four hours after the initial dose, the serum salicylate level had fallen from 558 to 416 micrograms per cubic centimeter and, after another twenty-four hours, to 226 micrograms per cubic centimeter. On the third, fourth and fifth days the salicylate levels were respectively 209, 169 and 189 micrograms per cubic centimeter. After the administration of sodium bicarbonate was discontinued, the serum salicylate level rose rapidly, and one, two, three, four, five and six days after the sodium bicarbonate was discontinued the salicylate levels were 270, 406, 461, 486, 465 and 506 micrograms per cubic centimeter of serum respectively. Equally striking effects were obtained in 3 other rheumatic patients.

Successive Daily Serum Salicylate Levels During (1) a Control Period When Sodium Salicylate Alone Was Given, (2) a Period When the Same Dose of Sodium Salicylate and Approximately Equal Amounts of Sodium Bicarbonate Were Given and (3) a Period When Sodium Bicarbonate Was Withdrawn and Sodium Salicylate Administration Was Continued

Subjects	Successive Daily Serum Salicylate Levels (Micrograms per Cubic Centimeter of Serum)																	
	1. Period During Which Subjects Were Taking Sodium Salicylate					2. Period During Which Subjects Were Taking Approximately Equal Doses of Sodium Bicarbonate and Salicylate									3. Period During Which Sodium Bicarbonate Was Withdrawn and Sodium Salicylate Continued				
A. J., active rheumatic fever	464	472	459	532	558	416	226	209	169	199	...	...	...	...	270	406	461	486	465
R. U., active rheumatic fever																			
1st period of study...	435	438	440	465	433	359	283	251	247	275	279	317	311	300	370	447	484	495	499
2d period of study....	415	447	459	420	422	355	275	184	199	189	181	161							
R. H., active rheumatic fever	...	411	438	453	438	398	240	157	190	185	...	...	...	...	267	356	380		
A. A., active rheumatic fever	405	419	427	457	420	305	263	277	258	...	...	...	...	...	380	439			
K. S., healthy woman.....	...	...	411	492	571	446	297	308	...	...	...	...	...	...	444	468			
R. W., healthy man.....	...	...	396	405	460	374	369	281	...	...	...	...	...	...	296	309	404		
R. D., healthy man.....	...	...	...	...	...	260	301	246	217	265	253	...	...	...	415	415			
P. E., healthy man.....	...	...	...	...	...	267	319	316	315	284	269	...	...	...	427	484			

These observations show clearly that a serum salicylate level which has been established and is being maintained by the oral administration of sodium salicylate is definitely lowered when approximately equal amounts of sodium bicarbonate are given simultaneously.

It was then thought to be of interest to investigate, in another type of experiment, what serum salicylate level can be established when equal doses of sodium

From the Department of Medicine, Columbia University College of Physicians and Surgeons and Presbyterian Hospital.

1. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. **73**: 435-464 (Dec.) 1943.

2. Brodie, B. B.; Udenfriend, S., and Coburn, A. F.: The Determination of Salicylic Acid in Plasma, J. Pharmacol. & Exper. Therap. **80**: 114-117 (Jan.) 1944.

3. A few determinations of salicylate levels on plasma and serum obtained from the same sample of blood showed that the serum levels are slightly higher than the plasma levels. This difference obtains whether the determination is done immediately after the blood has been drawn or after the blood has been allowed to stand as long as thirty-six hours at room temperature.

bicarbonate and salicylate are given simultaneously from the beginning of the experiment. The results obtained in a healthy man are shown in chart 2. In this experiment the serum salicylate level varied between 267 and 319 micrograms per cubic centimeter. When sodium

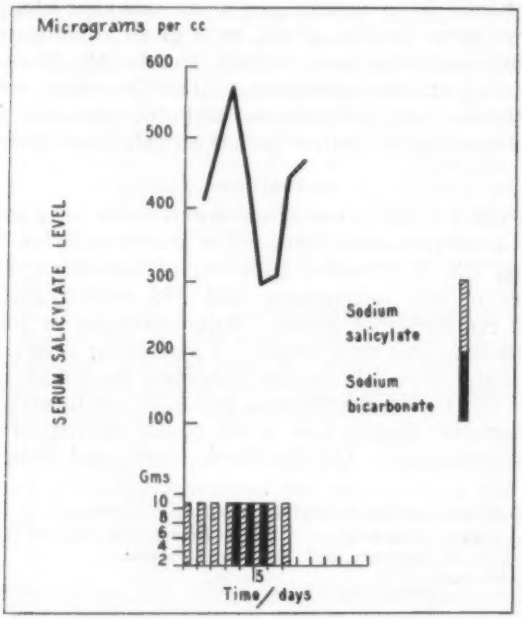

Chart 1.—Effect of sodium bicarbonate on the serum salicylate level of a healthy woman.

bicarbonate was withdrawn, the salicylate level rose to 427 micrograms per cubic centimeter within twenty-four hours and 484 micrograms per cubic centimeter within forty-eight hours. It is thus apparent that the

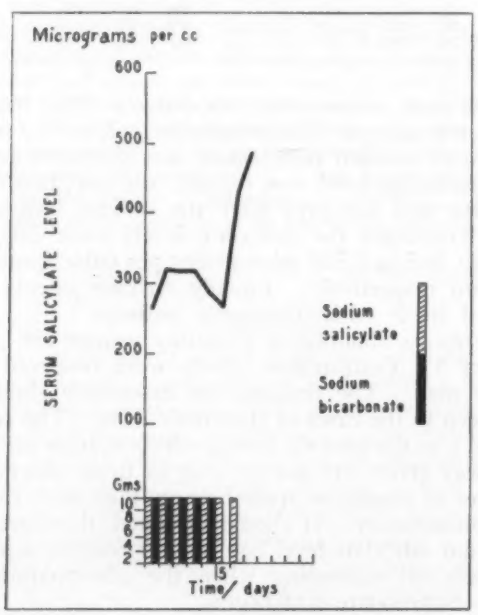

Chart 2.—Effect of sodium bicarbonate on the serum salicylate level of a healthy man.

simultaneous administration of equal doses of sodium bicarbonate and salicylate prevents the establishment of as high a salicylate level as is obtained when salicylate alone is given. The effect was similar with another healthy subject.

The results obtained in all the experiments are summarized in the accompanying table.

COMMENT

Recent studies by Coburn [1] suggest that the maintenance of a high salicylate level in the blood is important for the effective treatment of acute rheumatic fever. He has demonstrated that, whereas levels below 200 micrograms per cubic centimeter of plasma are sufficient to relieve the symptoms, it seems probable that a concentration of at least 350 micrograms may be required to suppress the "rheumatic reaction." Our observations show that sodium bicarbonate, in the amounts customarily given together with sodium salicylate, definitely depresses the blood salicylate level. The implication of this finding with respect to adequate salicylate therapy is obvious.

It was considered possible that a high concentration of sodium bicarbonate in the blood might invalidate the method of determining the serum salicylate level. The

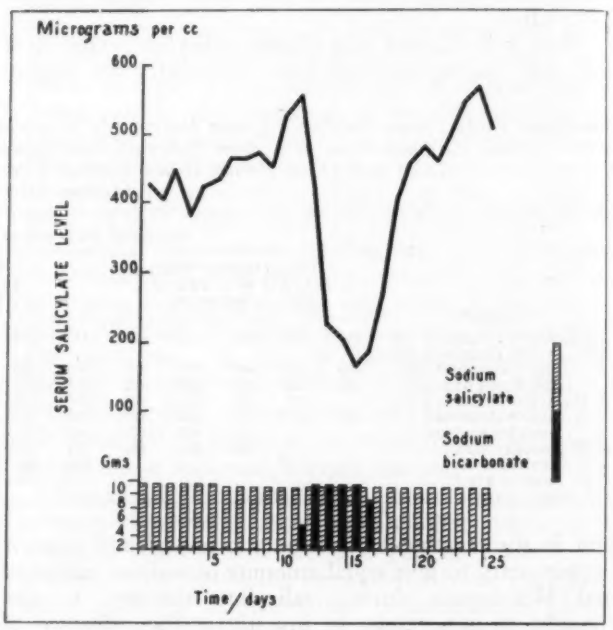

Chart 3.—Effect of sodium bicarbonate on the serum salicylate level of a man with acute rheumatic fever.

salicylate level was determined on samples of several serums. The determinations repeated after sodium bicarbonate had been added in the serums (2 mg. of sodium bicarbonate per cubic centimeter of serum) yielded identical results.

A priori, it would seem that the fall in the serum salicylate level caused by sodium bicarbonate could be due to one of a number of factors or to several acting together: (1) Sodium bicarbonate interferes with the absorption of sodium salicylate in the intestine; (2) sodium bicarbonate causes an increase of extracellular fluid which leads to a decrease in the titer of sodium salicylate in the blood; (3) sodium bicarbonate increases the renal excretion of sodium salicylate or its derivatives. At the present time it is not possible to say which of these may be responsible for the observed fact.

CONCLUSIONS

1. When a serum salicylate level has been established and is being maintained by the oral administration of enteric coated tablets of sodium salicylate, the simul-

taneous administration of approximately equal amounts of sodium bicarbonate results in a definite fall of the serum salicylate level.

2. The simultaneous administration of equal amounts of sodium bicarbonate and enteric coated sodium salicylate prevents the establishment of as high a serum salicylate level as would be obtained with sodium salicylate alone.

TREATMENT OF RECURRING ATTACKS OF LOW BACKACHE WITHOUT SCIATICA

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Recurring attacks of low lumbar backache, plus sciatica in the back of the leg, are almost pathognomonic of defective intervertebral disks. With few exceptions the backache and sciatica are intensified by coughing and sneezing during the periods of acute pain. A frequent story given by these patients is that for some weeks, months or years there are only recurring attacks of backache, i. e. without the sciatica, and that at a later date the sciatica is superimposed. Such histories suggest that with the recurrent backaches alone one is dealing with precisely the same underlying lesion as when the sciatica is added. This report of 20 cases is from this group, none of whom have ever had sciatica. Moreover, there is no greater uncertainty in the diagnosis of the lesion without, than with, sciatica; nor is there any greater difficulty in localizing the affected disk or disks. It is by no means to be inferred that all patients with recurring attacks of backache or backache with sciatica are advised to be operated on. There are many who can go along in comparative comfort by avoiding strains to the back. Operation is indicated when the backaches are frequent and severe. However, since the operation is without risk and the results are now excellent and permanent, there is no reason for patients to suffer, particularly since spontaneous cure is uncommon and requires many years.

DIAGNOSIS OF DEFECTIVE DISKS

From signs and symptoms alone, defective disks causing backache with or without sciatica can be diagnosed in approximately 95 per cent of all cases; with symptoms plus x-ray examination of the lumbar spine, in over 98 per cent. X-ray examinations serve to differentiate spondylolisthesis and congenitally defective vertebrae, both of which produce symptoms that are quite similar.

From x-ray examinations of the lumbar spine alone the diagnosis can be made in over half the cases. Narrowing of the intervertebral space is pathognomonic objective evidence of a defective disk. Not infrequently two disks are narrowed in the roentgenogram and occasionally all the lower three; at times, other disks are similarly affected. When multiple, they may or may not be affected in sequence. In 12 of the 20 cases in this series of disks without sciatica, this roentgenographic evidence was present.

Until recently, defective disks were diagnosed only by injections of iodized poppyseed oil, air or other contrast mediums into the spinal cord. In recent communications I have shown that these are never necessary and are always inadvisable, for the following reasons: 1. They diagnose and localize disks in only about one fourth of the cases because only the large disks produce a filling defect in the contrast medium. 2. They frequently give equivocal results and therefore unreliable information. 3. They are painful, and if a solid contrast material is used and removed (as it should be) it is a long and harrowing ordeal to the patient. 4. There are occasional temporary and even permanent after-effects from the injected material.

Since, seemingly paradoxically, defective disks can be diagnosed and localized in over half the cases by simple x-ray films and in only one fourth of the cases by spinograms, and since all disks can be diagnosed by the history and neurologic examination and x-rays without contrast mediums, there is no possible reason for using spinal injections in any form. They just don't make sense.

Spinal tumors (now about 1 per cent) give the only real difficulty in differential diagnosis. The signs and symptoms of tumors may be identical with those of a disk, but one can frequently suspect a tumor by some progressive sensory or motor change (these also occur with disks) or by loss or diminution of a patellar reflex (this also occurs with disks). I have missed 9 tumors of the cauda equina among 1,100 disks; 8 of these I found later; the ninth was removed by another surgeon. On the other hand, I have diagnosed and removed 5 additional tumors among patients whose symptoms were somewhat similar to those of disks. Five more cases of metastatic tumors in the spine have been left untreated; usually the pain in metastatic lesions is continuous and not recurring. If a tumor is suspected, a lumbar puncture should be performed (this is the only occasion for tapping the spine). Xanthochromic fluid will usually indicate a tumor, and its absence a disk. A Queckenstedt test should be made at the same time in order to determine a partial or complete block in the spinal canal. These tests are not absolute (they were lacking in 1 case) but are nearly so.

Twenty patients having backache without sciatica have been operated on during the past three years. The history is much the same in all cases, i. e. recurring attacks of low backache and nothing more. Usually, but not always, the pain is intensified by coughing and sneezing. Each attack lasts one to three weeks, after which the patient is relatively free from pain until a new attack is precipitated by a strain such as a heavy lift, a twist of the back, a fall or any sudden movement. There may, however, be no definite precipitating cause. Sixteen patients were males, and 4 were females.

A total of 32 disks have been removed from the 20 patients; of these, 7 were large, protruding and nerve compressing, although there had never been sciatica. Twenty-five of the 32 disks were of the so-called concealed variety, i. e. too small to have been diagnosed by contrast mediums had any been used. In 6, or nearly one third, of these cases, the recurring backaches dated back more than ten years, i. e. ten, thirteen, fourteen, eighteen, twenty-five and thirty years; the shortest duration of attacks was two years.

When this study was begun I had been removing the entire disks but not so thoroughly as at the present time. However, I did not know that disks were so frequently multiple (80 per cent). Fair judgment on results of disk treatment can therefore be made only after this new information has been utilized. This date has been set at June 1, 1943, one year ago. Ten patients in this series were operated on before and 10 after this date. Of the 10 cases before June 1, 1943, single disks were

removed in all; in 2 cases a second disk was subsequently removed when symptoms continued, and, in 2 more, additional disks are believed to be present because of continued backache. Of the 10 cases in which operation has been performed since June 1, 1943, none have required reoperation. One patient has some backache but not severe enough for another operation, and a second has severe pain but has lost confidence and will not return for examination or operation. It is my belief that both these patients have a third disk. Recurrence of the disk is possible but unlikely. The remaining 8 cases are free from backache. This period of one year is much too short to warrant any conclusions concerning the permanence of results; but in over 800 cases of disks (with sciatica) removed completely in the past two years there have been only 2 known recurrences at the operated disks (both over a year ago) and 3 instances in which

Bony union between fourth and fifth vertebrae four years after partial extirpation of the disk.

sciatica has returned on the opposite side (but at the site of the previously removed disk). Return of pain on the opposite side must always be a possibility—because it is difficult or perhaps even impossible to elevate the spinal dura sufficiently to remove the cartilage in this corner of the disk completely. This could be avoided by opening the contralateral side, but with such a low percentage of trouble from this source I prefer, for the present at least, to accept this liability rather than increase the magnitude of the operation.

The preceding statement of results means actual recurrence of a disk demonstrated at operation. It does not mean recurrence of pain for which another disk has been found to be responsible. There have been perhaps a dozen of these. Nor does this statement imply that a higher percentage of recurrences will not appear subsequently. But considering the high percentage of actual recurrences that obtained when disks were only partially removed, no doubt can remain of the much improved results after their complete removal.

Sufficient time has not elapsed to justify a dogmatic statement that complete removal of disks will result in a permanent cure; but if the operation is properly done, I do not see how a permanent cure can fail. This is therefore not a statement of fact but an impression from experiences up to the present time. To remove a disk completely or essentially completely is a tedious and time consuming procedure (about an hour for 2 disks). Doubtless even the most careful operator will have recurrences because of an incomplete attack on the disk, but the recurrences should be few; and in the last analysis it will be the surgeon's mistake and not the mistake of the method. To speak of complete removal of disks is not strictly accurate; an absolute removal of all cartilage is impossible, but the small amount that remains on the fringes of the vertebrae gives no trouble. The removal is essentially complete.

An important view of defective disks is this: Should symptoms recur, either in exactly the same or a different form after three or four months, the explanation can be found and corrected. There are three possible causes of continuing trouble: (1) a recurrence of the original disk, (2) another disk which was missed at operation or (3) a tumor of the spinal cord or cauda equina (about 1 per cent). At operation it is possible by the mobility test to tell which of the first and second items is the cause and to correct it.

Much stress has been placed on a psychogenic factor or malingering in case of continuing pains before and after operation. These are always possible factors both in the preoperative diagnosis and in the postoperative failure to cure. However, there should be little difficulty in interpreting these elements either before or after operation. A psychoneurotic backache is nearly always continuous and therefore does not have the remissions that are so characteristic of defective disks. And patients of this type will not volunteer that coughing and sneezing accentuate the backache or sciatica. Finally, and most important, the psychoneurotic element is evidenced by spreading of the pain up the back and to the arm and even to the head. Such extensions can have no organic explanation. As a matter of fact, I have found psychoneuroses to be uncommon factors; and, when present they are easily differentiated from the real. With few exceptions the patient is right when symptoms continue and the doctor's explanation of a functional background is wrong.

When a disk is defective, whether concealed or protruding, the joint is more movable than normal, and by pushing the spinous processes caudally with an instrument the affected disk or disks can be identified by this increased mobility. The only failure of this test occurs when there is a narrowing of the intervertebral space in the x-ray film; the joint may then be immobile or nearly so. This test is as effective in localizing the disks causing a backache without sciatica. In a single case in this group the disk was at the second lumbar vertebra, but local tenderness and x-ray findings indicated its higher location.

TYPE OF OPERATIVE TREATMENT

The treatment of defective disks is precisely the same for backache alone as for backache plus sciatica. The mere removal of the protruding portion of a disk is unsatisfactory in the long run because a high percentage —at least a third and, with additional time, probably more—will recur from the cartilage that remains, and

with concealed disks the protrusion is too small to be removed. The present operative attack on disks is to remove them as completely as possible with curets, baring the bone. The joint then narrows, and the cavity fills with connective tissue. This procedure does what nature attempts to do slowly over many years, as is evidenced by the narrowing in the x-ray appearance. Three months after complete excision of the disk the joint, when exposed at operation, is absolutely firm; this has been demonstrated repeatedly. It is believed that bony union will eventually ensue, but I have only a single case to warrant this supposition. Recently a patient was shown to have bony union after four years, as may be seen in the illustration, although at that time the disk was only partly removed. The complete removal of the disk causes no more immediate or late after-effects than the partial removal. There has as yet been no instance in which a joint has been known to become loose after healing. There is reason to believe that the permanent fixation of an excavated disk should be maintained precisely as after trauma causing fractures of the spine involving the disks.

THE CAUSE OF DEFECTIVE DISKS

The underlying cause of defective disks is an inherent weakness in the lower lumbar spine. A superimposed factor is trauma—such as a heavy lift or twist or bend of the back or a severe cough or sneeze—which may or may not be severe enough to be appreciated at the time. Specifically, the weakness of the spine is due to a shift in the direction of the planes of the lateral articulations between the last three lumbar vertebrae and the sacrum, particularly between the fourth and fifth vertebrae and the sacrum. At the first two lumbar vertebrae the lateral joints parallel the spinous processes; at the third lumbar the plane of the joint turns laterally 15 to 25 degrees; at the fourth it turns out 25 to 45 degrees, and at the junction between the fifth and the sacrum the joint may be everted as much as 90 degrees from the spinous processes. At four, and particularly at five, the joint may also be turned upward and face in varying degrees a craniocaudad direction. Many disks are flat or nearly so, instead of vertical, and this leads to the frequency of spondylolisthesis, especially at the lumbosacral angle. There are varying degrees of these changes in the joints and much asymmetry in the two sides. The purpose of the shifting articulations is doubtless to provide movement—flexion, extension and rotation in the back. At the same time they create definite weakness of the spine and allow any undue trauma, even very slight, to loosen the joint or joints; this weakness then transfers increasing trauma to the corresponding disk or disks. This structural variation also accounts for the high frequency of multiple disks.

CONCERNING CONCEALED DISKS

There can never be any disagreement concerning protruding disks. Surgeons have been reluctant to accept the so-called concealed disks, i. e. small disks that do not elevate the nerve, which I believe to be just as easily diagnosed and localized and treated as the large ones; and they are three fourths of the total number. Just as one can diagnose a small tumor of the breast as unequivocally as a large one, so the diagnosis of a small disk is just as definite as a large one. There is nearly always some actual protrusion; it fluctuates when pressed on by forceps; the overlying ligament is much more opaque than the normal; it is adherent to the surrounding structures, and when opened the forceps dip without resistance into a cavity and frequently sequestrums of varying size can be extracted. The location of the disk, whether small or large, is disclosed by the excess movement of the joint (the mobility test), except as previously noted, when the x-rays disclose a narrowing of the intervertebral space. The small concealed disks give precisely the same symptoms as the large ones, the only difference being the intensity and persistence of the symptoms—backache with or without sciatica. When sciatica is persistent and intense the disk will always be large and protruding, but a large disk may be present without intense symptoms, as in some of the cases here reported. By the symptoms one can usually predict the size of the disk. The treatment of small disks is precisely the same as of the large ones and is just as effective. Those who doubt concealed disks can never doubt the demonstrable increased mobility at the joint, which is the real source of symptoms; a loose joint must cause symptoms.

THE CAUSE OF BACKACHE AND SCIATICA

The cause of backache and sciatica cannot be stated with certainty. From a study of cases before and after operation, I now believe that the lateral joints and the corresponding disks are all participants and that probably the initial pain is from movement of the lateral facets and that the disk is secondarily and necessarily affected. The anatomic variation of the lower lumbar lateral facets, which is surely the cause of defective disks, suggests this. If the lateral facets are loose, the disk itself, which bears most of the weight of the spinal column, will participate in the increased mobility; thus all three joints are affected. Since at times the backache is unilateral, the lateral facet of one side is probably responsible for the backache; the mobile disk could hardly produce unilateral backache. A more obvious reason for believing that the loose facets cause the backache and sciatica as well is the postoperative story of an occasional patient after complete removal of the disk. In 3 patients an attack of severe backache and sciatica was precipitated immediately after they had got out of bed seven to ten days after operation. The attacks were identical with those before operation, but after the subsidence of symptoms a week or two later there was never a return of the symptoms. It can hardly be doubted that the lateral facets had slipped with the sudden application of weight, there being no disk to modify the strain. Certainly, the complete absence of the disk would eliminate protrusion of the disk as the factor in the sciatica. Therefore the sciatica, at least, must be referable to the lateral facets and probably was due to the swelling about these joints or possibly even to the actual slipping of the joint against the nerve.

Another reason for this explanation of the sciatica and backache is that in spondylolisthesis, in which the symptoms are identical, defective disks, either protruding or concealed, are not always present. Therefore it must be assumed that an explanation other than a disk must obtain—probably the slipped facets.

If this explanation is correct, it can be applied to the causation of backache and sciatica in the presence of concealed disks. It is difficult to explain sciatica on the finding of small disks that do not protrude against the nerve. It might be assumed that the disk, which is small at operation and probably even more reduced in size by the ventral position of the patient, might protrude inter-

mittently, especially under the influence of trauma, and then compress the nerve. The fact that the disk is usually adherent to the nerve or the dura or both also suggests that there has been preexisting pressure on the nerve. This explanation may or may not be satisfactory, but proof is lacking. It was my original explanation of sciatica before realizing that the lateral joints could probably cause it. Unless or until a disk actually compresses the nerve, it is more reasonable to assume that the lateral facets are responsible for the sciatica. How much of the backache is due to the lateral facets and how much to the disk itself can only be conjectured; both may play a part. The problem of defective disks, therefore, is one not only of the disk but of all three joints between the vertebrae; but always the disk is defective.

WHY REMOVE DISKS COMPLETELY?

If the lateral facets are responsible for much, at least, of the backache and pain, one may well ask Why attack the disks instead of the facets? The first answer is that the disk is probably always affected; the second, that stabilization of the facets by operation is difficult or at the present time, at least, impossible; the third, that the removal of the disk stabilizes the vertebral column by an actual fusion of the vertebrae, after which the facets take care of themselves. The disks offer a broad surface for fusion; the lateral facets are curved and small. In several instances I have opened the lateral joints and to some degree denuded the cartilage, but the total area involved is small and offers only a fraction of the stabilization offered by removal of the disk; even as a supplementary procedure it is probably of no practical value because fusion after extirpation of the disk is extensive and adequate. From an experience with 30 cases of reexplored disks (for recurrence of pain and before disks were known to be multiple) it is now known that the union between the vertebrae is so firm three months after a disk has been completely removed that there is no movement at the joint. If there is movement at the joint after this time the disk had not been completely removed and is therefore recurrent. And it is also known from exposures after an interval of a year that the joint remains solid; and from absence of symptoms after two and a half years there is no reason to believe that the healed space has changed in this respect.

WHY ARE FUSIONS (BONE TRANSPLANTS) OF THE SPINE TO BE CONDEMNED?

Most neurosurgeons still fuse a varying percentage of the cases in which disks are removed. The reason for this is that their experience with the operative treatment of disks has been unsatisfactory. The reasons for unsatisfactory results have been stated, i. e. (1) failure to remove the disks completely, thus obviating recurrence, and (2) the failure to recognize multiple disks. The use of bone grafts to the spine is therefore a confession of poor results. A fusion operation will improve the situation but little, if any, because the recurrent disk or the additional disk is merely covered up. After complete removal of disks the fusion of the spinal column is more nearly perfect than the most successful bone graft can be, and at the same time the cause is removed. Fusion by bone grafts is a big procedure and necessitates a prolonged stay in the hospital in a cast; fusion by removing the disks means hospitalization for only a week to ten days. I have reoperated on perhaps 15 patients who have had spinal grafts performed—all without relief of symptoms—and only 3 of the grafts persisted in position and afforded any stabilization of the spine; even these did not even modify the pain. It can be said unequivocally that in the treatment of ruptured disks a spinal fusion by bone grafts is never necessary and cannot be too strongly condemned.

Since removal of intervertebral disks appears to be a more rational method of stabilization of the spine, I have in the past year performed operations in 25 cases of spondylolisthesis of the lesser grades and 5 cases of congenitally defective vertebrae by extirpating the disk, instead of by spinal fusions.

CONCLUSIONS

1. Recurring attacks of low lumbar backache without sciatica have precisely the same underlying cause as backaches plus sciatica, i. e. defective intervertebral disks.

2. In one third of the 20 cases here reported there were large protruding disks compressing the nerve, despite the fact that sciatica had never been present.

3. The diagnosis of defective disks is made solely from the history, the neurologic examination (frequently negative) and x-ray examinations of the spine. The latter give pathognomonic evidence of defective disks in over 50 per cent of the cases.

4. The disks are localized at operation by the mobility test (movement of the affected joint).

5. Defective disks are multiple in 80 per cent of the cases, with or without sciatica.

6. All spinal injections for diagnosis or localization are unnecessary; they are painful, sometimes cause serious after-effects and at best make the diagnosis and localization in only 25 per cent of the cases, whereas over 98 per cent can be diagnosed and localized without them. Even simple x-ray films alone diagnose more than 50 per cent. Spinal injections of any type should be strongly condemned.

7. Recurrence of disks should be reduced to a minimum by their complete removal. This results in fusion between the affected vertebrae and obviates any necessity for fusion by spinal grafts: Fusions of the spine are never necessary! If backache or sciatica returns or persists there are three possible explanations: 1. A disk has been missed. 2. It has been incompletely removed. 3. There may be a tumor.

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Dermatology in Early Modern Europe.—At the beginning of the seventeenth century came the discovery of the microscope, which opened up the universe of the infinitely little, as the telescope did the universe around us. During this period medicine kept the pace; it carried its studies as far as could be done without the instruments of precision of the nineteenth century. Anatomy, physiology, pathology and clinical medicine were investigated to the limit of the resources of existing scientific knowledge. Medicine had a particular reason for the stimulation of its activity in the sudden appearance of syphilis at the very beginning of this period. The study of skin diseases was more than ever a subject of major interest in medicine, because of the cutaneous manifestations of syphilis, which emphasized the importance of skin diseases. The history of dermatology during the period is that of rapid increase in knowledge through the investigations of men, many of whom are the great figures in early modern medicine.—Pusey, William Allen: The History of Dermatology, Springfield, Ill., Charles C Thomas, 1933.

LACTIC ACID: A CORROSIVE POISON

REPORT OF THREE FATAL CASES WITH EXPERIMENTAL CONFIRMATION

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The common occurrence and physiologic role of lactic acid have tended to establish the general opinion that this substance is not to be considered as poisonous. Lactic acid is not mentioned in any of the standard textbooks on toxicology. We have been able to find only one reference to it as a cause of death in a human being. Leschke [1] cites a case described by Fühner [2] of a woman aged 27 who died in twelve hours after the administration by duodenal tube of 100 cc. of a 33 per cent aqueous solution of lactic acid in error for magnesium sulfate. This resulted in dyspnea, vomiting of blood and mucus, a rapid feeble pulse, hemoglobinuria and cyanosis. The autopsy revealed a dark red patch of erosion in the duodenum. Both duodenum and jejunum showed hemorrhagic infiltration of all coats and necrosing inflammation. Leschke remarks that "lactic acid has a corrosive action exactly like that of any other acid of corresponding hydrogen ion concentration." The dissociation constant of lactic acid (K_a) is usually given as 1.38×10^{-4} at 25 C.[3] This makes it comparable with formic acid at 2.14×10^{-4}, long considered a poisonous corrosive and almost ten times stronger than acetic acid, which has also been so classified when in high concentration.

From the experimental point of view there is confirmatory evidence. Dreyfus [4] has shown that the rectal administration of 40 cc. of a 3 per cent solution of acetic, butyric, lactic or tartaric acids to rabbits caused death in a few hours. Pike, Osnato and Notkin [5] injected lactic acid in doses of 0.07 to 0.1 Gm. per pound of body weight into cats to produce convulsions, which were later followed by death with respiratory failure and pneumatorrhexia. Lastly, Fürth and Engel [6] found that lactic acid given orally to rabbits in doses of 0.6 to 1.6 Gm. per kilogram of body weight caused death, and they quote Parnas as showing that 2.8 to 3.6 Gm. per kilogram could be given intravenously. They state that mice can withstand about the same dosage as rabbits but that rats are more resistant. In rats and mice alkalosis induced by sodium bicarbonate did not alter the effect.

Recently we were called on to investigate the cause of death of 3 premature infants. They were all being fed the same lactic acid milk mixture on the basis of the following formulas, and all ingredients had been used previously for the same purpose: (1) evaporated milk, water and acid sugar solution, equal parts; (2) acid sugar solution: water, 1 pint, corn syrup, 1 tablespoon, lactic acid (concentrated) 1 teaspoon.

REPORT OF CASES

CASE 1.—*Clinical History.*—Baby H., a very small white girl aged 35 days, weighing 3.85 pounds (1,746 Gm.), was found dying three quarters of an hour after receiving the lactic acid milk mixture by gavage. She was one month premature and weighed 3.38 pounds (1,533 Gm.) at birth.

Autopsy Findings.—The autopsy was performed within a few hours of death.

General Appearances: There were no excoriations on the face, mouth or lips.

Lungs: The right upper lobe showed minute peribronchial hemorrhages with pus exuding from the bronchioles. Microscopic examination revealed this to be a typical capillary bronchitis. Areas of emphysema, atelectasis and acute congestion were also present in the lung. The left lung showed only a little acute congestion.

Esophagus: There was a small black necrotic, eroded area at the cardiac end, extending into the stomach, which was confirmed histologically.

Heart: The heart was normal except for some cloudy swelling of the myocardium and a little terminal dilatation of the right side.

Peritoneal Sac: The peritoneal sac contained some blackish fluid stomach contents.

Stomach: This had perforated, and its blackish, mucous contents had exuded. Its wall was black, hemorrhagic, necrotic and extremely friable and the seat of an acute gangrenous gastritis.

Intestine: Except for a slight injection of the jejunum, the intestine showed no gross or microscopic change. The contents were not blood stained.

Mesentery and Omentum: These showed white necrotic areas on a black gangrenous background.

Pancreas: Gross examination revealed some blackening and superficial necrosis externally, but only some congestion was visible on microscopic examination.

Liver: There were areas of superficial hemorrhage and acute congestion with cloudy swelling of the liver cells, confirmed histologically. The under aspect of the left lobe was blackened from the action of sulfide.

Spleen: It was very soft, toxic and congested.

Adrenals: Except for some superficial discoloration of the left gland, they were normal.

Kidneys: The kidneys showed cloudy swelling and some congestion of the glomeruli but no nephritis.

Comment: The capillary bronchitis present in the right lung would appear to have been present before the poisoning in view of the short time which elapsed between the feeding with the lactic acid milk mixture and death.

Pathologic Diagnosis: Acute gangrenous gastritis, a result of corrosive poisoning; capillary bronchitis of the right lung; toxemia.

CASE 2.—*Clinical History.*—Baby C., a small white girl aged 37 days and weighing 4.33 pounds (1,965 Gm.), was found in a collapsed, pale, distressed condition with a feeble rapid pulse. She died three and one-fourth hours after receiving the lactic acid milk mixture by gavage. Although two months premature, she was otherwise healthy and weighed 3.63 pounds (1,581 Gm.) at birth. Oxygen and carbon dioxide were given without avail.

Autopsy Findings.—The postmortem examination was performed within four hours of death.

General Appearances: No excoriations were visible on the face, lips or mouth.

From the Departments of Biochemistry and Pathology, Dalhousie University.

Dr. F. V. Woodbury, medical coroner, referred the cases to us. Mr. F. A. H. Rice assisted with some of the experiments. Dr. G. B. Wiswell supplied the clinical data.

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Lungs: Both lungs showed acute congestion and there were some petechiae in the upper lobes. No evidence of pneumonic change, either gross or microscopic, was detected.

Heart: Except for one small petechial hemorrhage on its surface near the base of the left ventricle and some cloudy swelling in the myocardium, the heart was otherwise normal.

Peritoneal Sac: It contained some blackish stomach contents.

Esophagus and Stomach: There was a black gangrenous area in the esophagus ½ inch from the cardiac end of the stomach. The whole wall of the stomach was black and extremely friable and exhibited an intensely acute gangrenous gastritis with a small area of early erosion and perforation.

Intestine: The duodenum, jejunum and ileum all showed an acute enteritis, but the large bowel was relatively free, with nothing abnormal in the sigmoid or rectum.

Mesentery of the Small Intestine and Omentum: White necrotic areas were visible on a black gangrenous background.

Mesenteric Lymph Nodes: They were somewhat enlarged from a simple acute lymphadenitis.

Liver: The liver showed pronounced cloudy swelling and acute congestion.

Spleen: It was very soft, congested and toxic.

Kidneys: Both kidneys were the seat of cloudy swelling and acute congestion, and some petechial hemorrhages were seen at the upper pole of the left. No nephritis was present.

Pathologic Diagnosis: Acute gangrenous gastritis with perforation and acute enterocolitis, suggestive of corrosive poisoning; toxemia.

Case 3.—*Clinical History.*—Baby M., a small white boy aged 17 days and weighing 4.16 pounds (1,887 Gm.), was under observation for a longer time than the 2 previous infants as fifteen and one-half hours had elapsed between the feeding of the lactic acid milk mixture by gavage and death. The baby was born at seven and one-half months of term and was thus six weeks premature. The birth weight was 3.81 pounds (1,728 Gm.).

The main symptoms were those of pallor, collapse and a feeble, rapid pulse. There were no convulsions or vomiting, and no staining of the diapers was noted, such as would have been expected with a hemoglobinuria. Up to the time of the onset of the symptoms of poisoning the infant was healthy and progressing favorably. Nikethamide and vitamin K were given without result.

Autopsy Findings.—The autopsy was performed two hours after death.

General Appearances: There were no excoriations of the face, lips or mouth.

Lungs: The lungs showed only acute congestion and some petechial hemorrhages. No signs of capillary bronchitis or of pneumonia were present.

Heart: The myocardium showed cloudy swelling, but there was no other abnormal change seen.

Esophagus: The last 2 inches of its lower end were necrotic and gangrenous.

Stomach: As in the previous cases, the wall was blackened and hemorrhagic and was the seat of an acute hemorrhagic and gangrenous gastritis. No perforation, however, had occurred. The contents had a black color.

Intestine: Both the small and the large intestine were inflamed and the seat of an acute enterocolitis which extended down to the sigmoid colon.

Mesenteric Glands: They were enlarged and showed an acute lymphadenitis.

Liver: There was a pronounced cloudy swelling, fatty degeneration and acute congestion with small scattered areas of hemorrhage. Although a slight increase in the cells in the portal tract areas was visible, no true toxic necrosis could be identified on microscopic examination.

Spleen: It was slightly enlarged, soft, toxic and intensely congested, with hemorrhagic areas through the pulp.

Kidneys: Both showed considerable cloudy swelling with some necrosis of the secreting tubules, diffuse congestion of the blood vessels and some generalized swelling of the glomeruli, with congestion of their capillaries. The condition present had the character of an acute catarrhal nephritis or nephrosis. No accumulations of hemoglobin were visible in the collecting tubules.

Urinary Bladder: This was normal and contained practically no urine.

Pathologic Diagnosis: Acute gangrenous gastritis and acute enterocolitis with acute nephrosis or catarrhal nephritis, a result of corrosive poisoning; toxemia.

Case 4.—The same lactic acid milk mixture was also given by bottle to a 10 day old full term infant, but after one mouthful, which caused choking and reddening of the face, the baby spit it out and refused to take more.

Dr. Wiswell informs us that the baby developed an infected throat and suffered from a little bronchial irritation with wheezing for a day or two but made a complete recovery. Refusal to take the mixture evidently was the means of saving its life.

CHEMICAL EXAMINATION

Unfortunately, the acid milk mixture fed to the babies was thrown away immediately after the first death was discovered and was therefore not available for analysis. Furthermore, the amount of the mixture taken by the babies was not exactly known, but it was probably about 1 ounce. The various ingredients were, however, examined qualitatively and the hydrogen ion concentration determined either colorimetrically or electrometrically by a Beckman p_H meter. All conformed to their labeled contents. The corn syrup was acid, with p_H at 4.63, and the evaporated milk at p_H 6.7. The lactic acid possessed a specific gravity of 1.2, corresponding to the U. S. P. syrupy variety at 85 per cent with a p_H less than 1.

The stomach contents, together with peritoneal fluid, from case 1 measured 25 cc. of a dark brown mucous liquid without curds and with a slightly sour odor. The p_H was 2.5. The p_H of the stomach contents in case 2 was 3.0 and in case 3 about 5. A determination of the content of lactic acid in the stomach contents in case 1 was carried out according to the technic of clarification of Gerty T. Cori [7] and of estimation of Friedmann and Kendall [8] with the apparatus of West.[9] The concentration was 0.19 per cent lactic acid, or a total of 41 mg. in the whole specimen.

EXPERIMENTS WITH RABBITS

The experimental feeding of the milk mixture with an increased amount of lactic acid was next tried on adult rabbits. The formula used was made up of equal parts of the original evaporated milk, water and the concentrated lactic acid (85 per cent). This mixture was rather disagreeably acid to taste and had a p_H of 2.1. It was 34 per cent (w/v) lactic acid. The casein curd which formed initially dissolved as the hydrogen ion concentration passed to the acid side of the isoelectric point.

Rabbit 1.—One ounce, i. e. approximately the amount of the feeding estimated by the nurse, of this mixture was given by stomach tube to a 6 pound rabbit which had not been fed for about twelve hours. The animal was soon obviously distressed,

7. Cori, C. F.: The Influence of Insulin and Epinephrine on the Lactic Acid Content of Blood and Tissues, J. Biol. Chem. **63**: 253-268, 1925.
8. Friedmann, T. E., and Kendall, A. I.: The Determination of Lactic Acid, J. Biol. Chem. **82**: 23-43, 1929.
9. West, E. S.: An Improved Lactic Acid Apparatus, J. Biol. Chem. **92**: 483-485, 1931.

and the respiration became labored at 64 per minute in one hour. The rabbit died suddenly in convulsions within two hours. There was no vomiting, defecation or urination throughout the period. This would indicate death following a dose of 10.2 Gm., or about 1.7 Gm. per kilogram, i. e. 0.77 Gm. per pound for this rabbit. This dosage is of the same order of magnitude as the minimum lethal dose recorded by Fürth and Engel [6] at 0.6 to 1.6 Gm. per kilogram. At autopsy the stomach was found greatly distended with fluid containing mucus, blood and much fecal material. The fundic portion of the wall was very thin and near to perforation. The mucosa showed an intense, hemorrhagic, almost gangrenous, acute gastritis. The duodenum was soft and congested, and the rest of the small intestine was essentially empty. The jejunum showed some hemorrhages into its mucosa in the upper portion. The spleen was congested, rather soft and toxic, with some hemorrhages into the pulp. The kidney showed only some congestion and cloudy swelling. The lungs were edematous, congested and hemorrhagic but showed no evidence of capillary bronchitis or bronchopneumonia. The urine was scanty (2.5 cc.), very turbid with amorphous phosphates and distinctly alkaline (p_H 8.8). There was no protein or sugar present. The pathologic diagnosis of cause of death was acute hemorrhagic gastroenteritis. This is a striking confirmation of the suspected cause of death of the 3 babies, as the clinical and pathologic pictures were so similar.

RABBIT 2.—Another animal, weighing 5 pounds, was fed by stomach tube 30 cc. of a mixture of 2 parts whole milk to 1 part lactic acid (U. S. P. 85 per cent). This solution had a p_H of 1.58. The rabbit had been starved for sixteen hours previously. It was our purpose to study the effect on the alkali reserve of the blood in this animal and to determine the rate of absorption of the lactic acid. The respiratory rate was very rapid throughout most of the period, beginning at 150 per minute, rising to 240 in one hour and falling to about 200 until shortly before death, when the deep, slow Kussmaul respiration set in. The animal died in convulsions six hours after the administration of the lactic acid.

The alkali reserve of the blood was measured periodically in the Van Slyke apparatus [10] on oxalated plasma. Prior to the experiment it was 44 volumes of carbon dioxide per hundred cubic centimeters of plasma. At thirty minutes it was 38, and just prior to death 33.

The findings at autopsy performed immediately after death were essentially as recorded previously. The stomach contained 144 Gm. of a semifluid brownish mass with some characteristic fecal pellets. It had a slightly sour odor. The p_H was 3.30. The concentration of lactic acid was 1.91 per cent (w/v) and the total in the stomach contents was 2.75 Gm. As the amount originally administered was 10.1 Gm., there thus remained only 27.5 per cent unabsorbed after about six hours. This figure is in agreement with the determinations of Cori [11] on the rate of absorption of 12 to 15 per cent sodium lactate from the intestine of the rat. She found 25.8 per cent absorbed in the first hour, 44.9 per cent in the second, 59.1 per cent in the third and 69.7 per cent in the fourth. Our figure was 72.5 per cent in six hours. The concentration of lactic acid in the original solution, from which the feeding mixture was prepared, was determined after boiling for thirty minutes with excess of normal sodium hydroxide to hydrolyze the lactone and titrating the excess with normal hydrochloric acid. The concentration was 84.2 per cent.

RABBIT 3.—A similar experiment was carried out with another rabbit, except that the animal was allowed to swallow about 20 cc. of the acid milk mixture naturally. Measurement of the alkali reserve showed values of 67 at the start of the experiment, 38 after three hours and 43 after eight hours. The animal died during the following night, in approximately forty hours.

RABBIT 4.—A similar experiment on another animal fed 30 cc. of the acid milk mixture by stomach tube resulted in death with convulsions in ten minutes. There was no vomiting, but a blood stained froth was visible at the external nares and the lungs were noticeably edematous. In this case the stomach was so eroded that it ruptured on removal from the abdominal cavity. There were about 100 cc. of contents present.

COMMENT

From these observations and experiments it would seem obvious that lactic acid must be considered as a corrosive poison. The explanation of the deaths of the 3 babies is probably to be found in the administration of an acid milk mixture containing too high a concentration of lactic acid. This resulted in hemorrhage and erosion of the gastric and duodenal mucosa such that death resulted in toxemia from severe gastroenteritis. The interval prior to death was forty-five minutes in case 1, three and one-fourth hours in case 2 and fifteen and one-half hours in case 3. The rabbits died in ten minutes, two hours, six hours and about forty hours after identical doses. From the experiments with rabbits it does not appear as if the resulting acidemia was a major factor. That it has an effect, however, is apparent from the reduction in the alkali reserve of the blood. This aspect has been studied by Cohen,[12] who showed that intravenous injection of lactic acid at 0.045 Gm. per kilogram caused increased respiratory rhythm both in rate and amplitude but that the response was not specific for lactic acid. Rodler [13] has also shown that lactic acid milk containing 6 Gm. per liter tended to produce an acidosis as measured by increased urinary acidity and decreased excretion of phosphate.

In comparison with the recognized toxicology of acetic acid it is not surprising that lactic acid, a much stronger acid, should also be considered as a corrosive poison. Due care should therefore be exercised in the labeling and dispensing of this reagent so commonly used in the feeding of infants.

SUMMARY

The deaths of 3 premature infants have been investigated, both pathologically and chemically, and found to be due to an acute hemorrhagic and gangrenous gastritis. The deaths occurred in 0.75, 4.25 and 15.5 hours following the administration of an acid milk mixture containing an excess of lactic acid. The 2 babies who were larger and lived longer also showed an acute enterocolitis, and the 1 who lived for 15.5 hours had, in addition, an acute catarrhal nephritis or nephrosis.

After administration by mouth of a lactic acid milk mixture containing 10.1 Gm. in 30 cc. to rabbits, death followed in ten minutes and two, six and forty hours in 4 animals. The symptoms and findings were identical with those of the infants and death was attributed to acute hemorrhagic gastritis. There was a moderate degree of acidosis.

Lactic acid must therefore be regarded as a corrosive poison, and due care must be exercised in its use as an infant food.

Department of Biochemistry, Dalhousie University.

10. Hawk, P. B., and Bergeim, O.: Practical Physiological Chemistry, ed. 11, Philadelphia, P. Blakiston's Son & Co., 1937, pp. 499-503.
11. Cori, G. T.: Studies on Intestinal Absorption: I. The Absorption of Lactic Acid, J. Biol. Chem. **87**: 13-18, 1930.
12. Cohen, S. J.: The Effect of Lactic Acid on the Respiratory Center, J. Pharmacol. & Exper. Therap. **11**: 221-228, 1918.
13. Rodler, E.: Ueber die Beeinflussung des Säurebasenhaushalts beim Säugling durch die Verfütterung von Milchsäure- und Zitronsäuremilch. Ann. pædiat. **153**: 209-221, 1939.

TYPICAL PARACHUTE INJURIES

A STUDY OF THOSE OCCURRING IN 250,000 JUMPS AT THE PARACHUTE SCHOOL

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AND
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Parachute jumps at the Parachute School have increased progressively from their inception in 1941 to the time of this writing. Parachute injuries at the Parachute School have proportionately decreased progressively until at the present time a "jumper" has roughly only 1 per cent chance of being injured in any way in any one parachute descent. This remarkable increase in parachute activities, in spite of the decrease in injury rate, establishes a wealth of clinical material for study. This clinical material has been used in preparing this report.

Certain types of training injuries and jumping fractures have occurred repeatedly until there now exist several clinical entities recognized as typical parachute injuries. These will be discussed subsequently.

In this report we have analyzed the material at hand according to:

1. The type of injury most common to each of the four training stages and the anatomy, physiology and, where possible, the mechanics involved in producing the injury.

2. The immediate and follow-up care of the injured provided at the Parachute School.

3. New training technics and apparatus accounting for the diminishing injury rate.

4. New selection methods employed in choosing parachute personnel.

An "injury" has been arbitrarily chosen as a condition directly resulting from training which causes the student to lose one day or more from duty. Minor sprains, lacerations, contusions or exhaustive states which can be rehabilitated at the Parachute Medical Unit and returned to duty within a few hours are not considered statistically as "injuries."

The parachute course of training consists of four stages briefly described here for the purpose of orientation:

STAGE A.—Calisthenics, rope climbing, running and jumping from low 4 to 6 foot platforms into sawdust pits.

STAGE B.—Tumbling, trainasium, landing trainer, jumps from mock doors (4 to 6 feet), jumps from mock towers (30 to 35 feet) and suspended harness drill.

STAGE C.—Daily jumping from the 250 foot towers (free and controlled) and landing by parachute on sawdust. Tumbling is reviewed and parachute control is practiced.

STAGE D.—In which the applicant makes the necessary number of plane jumps to qualify as a parachutist, the jumps being made from a plane in flight and the landing being made on level and uneven terrain.

The physical hardening accomplished through stage A training put most applicants at something near physical perfection. It has been found that men physically at their best are less prone to develop fear phenomena in the apparatus of the next three stages.

The right rectus muscle strain or tear has proved to be the most frequent cause of disability in stage A training and the most interesting clinically, since it closely simulates acute appendicitis. This occurs in rope climbing, presumably when the lower extremities are raised at right angles to the body and the legs grasp the rope, as shown in figure 1.

It is believed that in the attempt to reach the top of the rope an unusually strong effort is made, in some cases causing a definite sharp pain in the abdomen and resulting in the following clinical syndrome. The patient appears at the Parachute Medical Unit complaining of pain in the abdomen and walking slightly flexed at the hips. The simple process of getting on the examining table is difficult because of the pain. With the patient standing, the abdomen appears relaxed, there being no effort to "hold the abdomen in." In cases with hematoma formation a definite bulge can be seen along the course of the rectus muscle. Inspection further reveals some subcutaneous ecchymosis

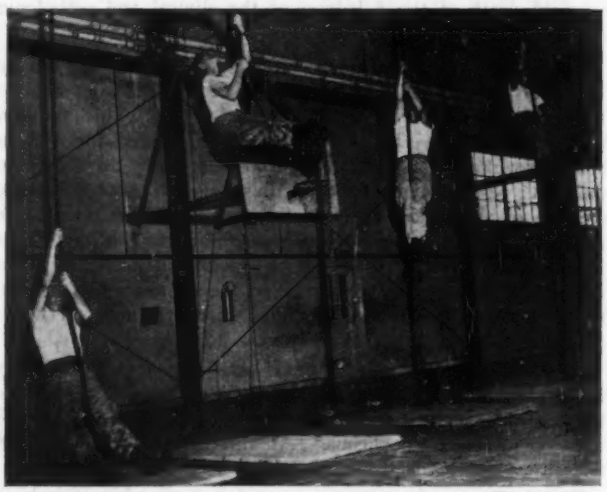

Fig. 1.—Mechanism of right rectus muscle strain, or tear.

(after four to seven days have elapsed) extending downward from the point of maximum tenderness. The muscle is exquisitely tender on light palpation, and the patient resists any sort of deep pressure. When asked to raise the body from the prone position, keeping the lower extremities flat on the table, he experiences severe pain. Ninety per cent of these cases are in the right rectus and 10 per cent in the left. It is believed that this is due to the effort exerted being greater on the right side in the majority of cases. A white blood count of 9,000 to 11,000 occurs the day after the injury. Polymorphonuclear leukocytes range from 70 per cent to 80 per cent. Now that the cause is determined, the diagnosis can be readily made, but many have been hospitalized for observation for appendicitis. One patient was operated on. The wound was closed and the appendix not removed. A hematoma below the rectus was found.

Since the act of tumbling has proved effective in disseminating the shock of landing when contact is made with the ground, the proper technic of tumbling is drilled into the applicant over and over again daily until a smooth, properly executed tumble automatically follows contact with the ground from any height. This

Figures quoted were obtained from the official records of the Parachute School.

Acknowledgment is made of the active cooperation of the X-Ray and Orthopedic Services at Station Hospital, Fort Benning, Georgia.

Major Lord is Surgeon and Lieutenant Colonel Coutts is Assistant Commandant at the Parachute School. Both authors are qualified parachutists.

The photographs were reproduced through the courtesy of the Post Signal Photo Laboratory, Fort Benning, Georgia, and Base Photographic Section, Lawson Field, Georgia.

emphasis on tumbling leads to the typical injury of stage B, the acromioclavicular contusion and the acromioclavicular separation. Figures 2 and 3 show two training situations involving tumbles which are being properly executed.

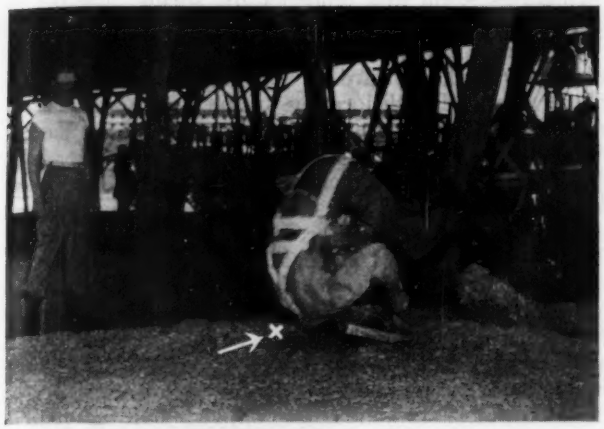

Fig. 2.—Tumbling from the landing trainer. Arrow indicates point of most forcible contact with ground. If improperly executed, the point of the shoulder strikes with greatest force, resulting in acromioclavicular injury.

The shoulder tip should not touch the ground; the forearm held rigidly by the triceps acts as a bar over which the body rolls. When the triceps muscles are relaxed the shoulder comes in direct contact with the ground at point X, indicated by the arrow, and the acromioclavicular injury occurs. Separation of the acromioclavicular joint in these injuries involves only the tearing of the articular capsule in some cases, the coracoclavicular ligaments remaining intact, preventing the scapula and acromion from being displaced downward. In the more severe cases the capsule and the coracoclavicular ligaments are torn and the acromion, being completely separated from the clavicle, is displaced downward by the weight of the upper extremity. In figure 4 the acromioclavicular separation is pronounced but the scapula and acromion are depressed only slightly.

Fig. 3.—This illustrates in greater detail the mechanism of acriomioclavicular injury.

In this case it was felt that the coracoclavicular ligaments were stretched but maintained the connection to the clavicle. This patient was treated with a block in the axilla strapped to the body; an additional strap extended up over the lateral end of the clavicle over the shoulder and down posteriorly attaching to the block behind the axilla. The elbow was raised by means of a sling. The man returned to full jump duty after five months and has now qualified as a parachutist with no symptoms referable to the shoulder. The less severe injury, namely the simple acromioclavicular separation with slight, if any, tearing of the capsule responds to immobilization of the upper arm and shoulder for two to four weeks. Those patients are ready for full parachute duty in this length of time without any treatment other than physical therapy and rest.

In stages C and D the injuries have a common cause, namely landing via parachute. The injuries, while more frequent in stage D, involve the same mechanism and the two will be described together. There are two typical parachute leg injuries. The first typical parachute injury resulting from a parachute jump is the double fracture involving the lower third of the fibula and the posterior lip of the tibia. The mechanism of this fracture is explained on the basis of a double force. It is thought that the foot is rotated externally and forced posteriorly on contact with the ground when this fracture occurs. When the foot is rotated externally, the anterior portion of the body of the talus (astragalus) presses against the anterior border of the inner

Fig. 4.—Typical acromioclavicular separation.

surface of the external malleolus, forcing it outward and backward. If the force is sufficient and if the inferior tibiofibular ligament remains intact, this force tends to cause an oblique fracture of the lower end of the fibula, usually about 2 inches above the tip. The posterior force is the result of the forward motion of the foot as it strikes the ground. The impact is transmitted up the metatarsals, through the tarsus, forcing off the posterior tibial lip. In the presence of a ground wind and with oscillation at the time of landing a more violent eversion of the ankle may occur, resulting in the trimalleolar fracture described by Lewin [1] in his study of the foot and ankle. In these cases fracture of the internal and external malleoli and the posterior tibial lip occurs. This trimalleolar fracture, however, is considerably less frequent than that involving the fibula and posterior tibial lip alone.

Figure 5 shows the foot and leg position and landing attitude as the parachutist approaches the ground. Figure 6 shows a fracture of the ankle involving not only the usual lower end of the fibula and posterior tibial lip but also the internal malleolus, which occurs in the more violent eversions of the ankle with landing.

These fractures were common prior to some recent changes in landing attitudes. The "original parachute

1. Lewin, Philip: The Foot and Ankle, ed. 2, Philadelphia, Lea & Febiger, 1941.

fracture" has recently begun to be replaced by a fracture of the upper third of the fibula or dislocation of the fibula head. This is due to the greater support of the ankle by having both feet held firmly together at the moment of striking the ground. However, coincident with this decrease in this fracture there has been an increase in fractures of the upper third of the fibula and also in dislocation of the fibular head. Since the latter situation is simpler to handle surgically, and since the convalescent time is substantially less, this is considered a favorable change.

Fig. 5.—Parachutists in descent. Preparation for contact with ground has been properly made.

This second "typical parachute injury" we have called the "silent fracture," since frequently the upper third of the fibula will be fractured and the patient will exhibit few, if any, symptoms. It is not unusual that the fracture will occur in stage C and the soldier proceed with the actual plane jumps of stage D before reporting for medical care. Figure 7 shows a fractured fibula occurring on Friday of one week and being reported at the medical unit on Tuesday of the next week with "a little" pain. It is our belief that a fracture of the upper third of the fibula could very frequently be misdiagnosed as a strained muscle if the possibility of this "silent" fracture should not be kept in mind.

Such a relatively painless pathologic condition can undoubtedly occur only because the fibula does not enter into weight bearing. In a series of 35 cases diagnosed recently, only 10 were reported for treatment at the time of the fracture. The other 25 were reported for "slight pain" in the upper outer aspect of the leg seven to thirty days after the injury. Many showed definite callus formation at the original x-ray examination. It is felt that some cases of fractured upper third of the fibula are never diagnosed as fractures. They have become more frequent in our series as the lower fibula fractures decrease with the ankle support afforded by landing with the feet and ankles held firmly together.

Dislocations of the fibular head have occurred now in a small series of cases but are becoming more frequent as the ankle injuries diminish in frequency. Figure 8 shows the fibular head in a dislocated position.

It is felt that the sideward landings which occur in oscillations result in a tendency to "spring" the fibular head from its position or fracture it in the upper third.

Key and Conwell [2] mention the possibility of backward, forward, outward or upward dislocation of the fibular head. The dislocations of the fibular head occurring in the parachute landings are primarily lateral dislocations resulting from the "springing" action described. The attachment of the tendon of the biceps femoris would tend to dislocate it posteriorly and upward, but we have not seen this happen in our series. The diagnosis is not difficult, since the bone is subcutaneous and can be readily palpated. These dislocations are sometimes reduced on the jump field by the ambulance surgeon or at the parachute medical unit after x-ray examination. The procedure is strong inversion of the foot and direct pressure over the fibular head. An elastic bandage is applied and the patient put on crutches and kept ambulatory. We have seen no evidence of peroneal nerve involvement yet. One medical officer in parachute training having a dislocated fibular head reported a numbness of the foot lasting several days after the accident. There was no tendency to muscle weakness "or foot drop." We are of the opinion that the relations of the peroneal nerve to the fibular head are such that with slight or moderate dislocation of the fibular head no pressure is exerted on the nerve. Furthermore, reduction is accomplished very early in these cases, and if pressure on the nerve does occur it is relieved promptly.

These two clinical syndromes, one involving the ankle, the other involving the upper fibula, are showing signs of persistence of occurrence with thousands of jumps weekly and are now considered classic parachute entities.

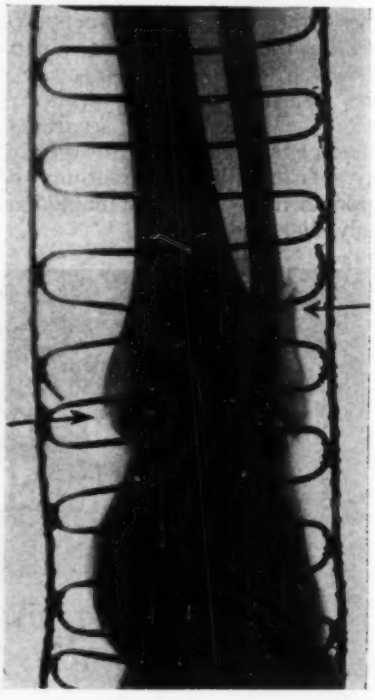

Fig. 6.—Typical parachute ankle fracture, involving both tibia and fibula.

With the opening shock of the parachute while the soldier is falling freely, any type of fracture or injury may occur if the body position is incorrect. The most unusual, recently, was a deep laceration of the perineum extending from the scrotum to and involving the sphincter ani and extending deeply, exposing the lower segment of the rectum. This was caused by the parachutist doing a forward somersault in the air with his legs apart before the parachute opened. The suspen-

2. Key, J. A., and Conwell, H. E.: The Management of Fractures, Dislocations and Sprains, ed. 3, St. Louis, C. V. Mosby Company, 1942.

sion lines went between his legs. When the parachute opened in the propeller blast, the great force of the taut suspension lines was exerted on the perineum, causing the deep laceration described. When the body position is normal, this great opening force is directed to the body harness from the suspension lines. It is thought that this accident occurred because the parachutist "dived" rather than "jumped" from the plane in flight and because he neglected to keep his feet and legs together at the exit. Such cases are rare but are of great clinical interest because they show the hazards involved when the "rules" are not followed.

Fig. 7.—So-called silent parachute fracture of upper fibula. The term "silent fracture" has been coined to indicate the relatively painless nature of this fracture.

IMMEDIATE AND FOLLOW-UP PROVISIONS FOR CARE OF THE INJURED AT THE PARACHUTE SCHOOL

Fractures, discussed in this article, are seen long before swelling has time to occur, because of the preparedness which exists in the Parachute School for immediate handling of injuries. Frequently fractures can be palpated by the examining physician before the obscuring action of edema has intervened.

Injuries occurring in stages A, B and C are picked up by the ambulance from the Parachute Medical Unit within a few minutes from the time of the injury. Jumping injuries occurring in stage D are handled as follows: On the jumping field there is an aid man assigned to watch the descent of every parachutist. He is within 6 feet of the parachutist when the latter lands. If there is any evidence whatever of injury, the aid man unfolds his red flag. Two ambulances and doctors are assigned daily to the field. One responds immediately to a waving red flag. The diagnosis is made within a matter of two minutes, as a rule, from the time of injury. The injured member is splinted and transported to the Parachute Medical Unit, where x-ray films are taken. Wherever possible, if no fracture exists, ambulatory treatment is encouraged. Men with fractures are admitted to the hospital; men with sprains, regardless of their severity, contusions, and the like, are supplied with crutches and kept mobile.

On two occasions the Parachute Medical Unit has conducted a series of studies to determine the advisability of injecting procaine hydrochloride for sprains. The immediate relief of discomfort by this method cannot be disputed. However, with early icing, tight binders and the use of crutches for twenty-four hours the pain is not a troublesome problem. It is believed that procaine injection has definite value in chosen cases with severe pain or for those who must walk immediately. The great majority, however, are not injected with procaine in our present method of treatment. The length of disability is not shortened by procaine injection in our series. This may be due to the fact that almost complete healing is required before a soldier is permitted to return to jumping status.

In the first twenty-four hours tight bands, icing and immobilization constitute the treatment of preference. After the first twenty-four hours warm applications, gentle massage and early active motion is the course followed. The physical therapy department in the Parachute Medical Unit handles hundreds of men daily, using infra-red lamps, ultraviolet rays, whirlpool baths, alternating hot and cold baths, and massage.

NEW TRAINING TECHNICS AND APPARATUS ACCOUNTING FOR THE DIMINISHING INJURY RATE

It is believed that certain revisions of the landing method taught at the Parachute School are in some measure responsible for a distinctly diminishing injury rate. This decrease was accomplished in spite of an increase in the training load of the Parachute School since July 1943. A revision of technic entailed:

1. Landing with the feet together, legs bent slightly at the knees, and the weight of the body slightly forward over the feet. Legs are held so that the knees are together. The muscles are not tensed, yet not relaxed. The leg muscles are alert to take up the landing shock.

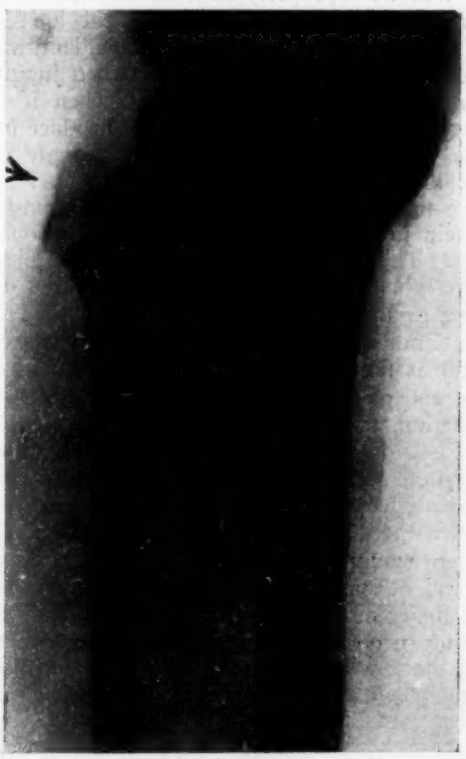

Fig. 8.—Typical dislocation of fibular head. Here, as in the "silent fracture," one notes a minimum of symptoms, which are infrequent.

2. A variation of previously taught tumbling technic so that proper landing can be made during ground approaches that are angular to the line of drift during a parachute descent. It was discovered that, although the desired approach was a forward drift then landing (fig. 5) in a large percentage of instances, backward or oblique landings occurred.

Further diminution of the injury rate was accomplished by exacting supervision of each student during this period of training before entering stage D. Careful attention to the maintenance of all equipment and training aids was found also to have some value.

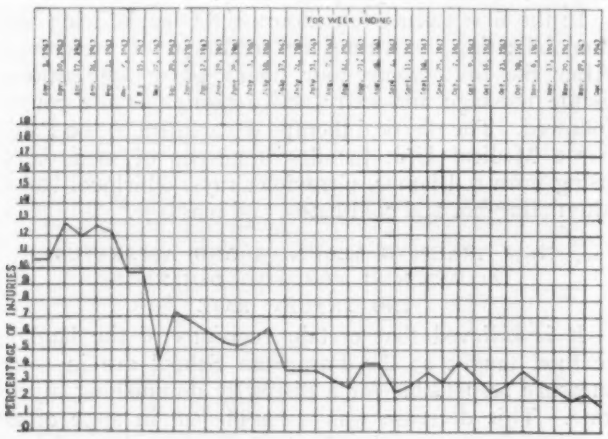

Fig. 9.—Graphic representation of the fact that all injuries in both the jumping and the prejumping stage have been materially decreased. Weekly percentage includes injuries in all four stages of training.

A study of the parachutists in figures 3 and 5 shows the value of the training the candidate receives in stages A, B and C. Figure 5 indicates lessons in landing technic that were properly learned. In the early days of parachute training when the student load on the school was small, the assistant commandant was able to select the most favorable weather when jumping his novices for qualification. However, when it became necessary for the Parachute School to produce material increase in its output it became increasingly difficult to pick ideal jumping weather for the novice. The directive to "qualify the men" made it impossible to limit their jumping to ideal weather conditions as in the past. The decreased injury percentage appears all the more remarkable in view of these conditions.

Strong ground winds frequently set up a pendulum-like motion of the parachutist, in which the apex of the parachute is the fixed, and the parachutist himself the moving, end of the pendulum. This swinging motion, or oscillation, as it is termed, can materially reduce the parachutist's opportunity of making an uninjured landing. When the old method of landing was taught, the novice's feet were approximately the width of the hips apart when landing. It is apparent that a sideward oscillation would bring the landing shock of all the body's weight on one or the other foot. This increased the possibility of sprain or fracture. The new method of landing, i. e. with the feet together, distributes the landing shock with almost perfect equality to both feet and legs when coming in for an oscillating landing. Careful records maintained at the Medical Unit, the Parachute School, covering thousands of injuries, have permitted the preparation of the chart presented as figure 9.

The new method of landing was inaugurated in stage A on June 12, 1943. It will be noted that since that time there has been a decided decline in the combined weekly injury percentage. This average was not subjected to the violent fluctuations which had previously characterized it. Comparison of the 1943 seasonal averages with those of 1942 reveals that in each case the combined percentage is lower.

SELECTION METHODS EMPLOYED IN CHOOSING PARACHUTE PERSONNEL

The selection of parachute personnel is done with the utmost care. All incoming applicants to the school have first been examined by their unit medical officer, who is supplied with a copy of the physical requirements for parachute admission. This serves as a gross screening process in weeding out obviously poor material. On admission to the receiving battalion at the Parachute School, all men are subjected to an examination system at the Parachute Medical Unit which rules out anatomically and psychologically poor material. The men are passed through a series of rooms and individually examined from a psychiatric point of view with stress being laid on various phobias for the detection of any lack of desire for training of this severity. They then proceed through the various stages of the physical examination, with particular stress being placed on anything which is symptomatic at the time, such as old lumbosacral sprains, old painful fractures, old retracting scars and any history of symptoms referable to the head, such as dizziness, blackouts or fainting spells. Potential hernias are ruled out for fear of exaggeration while in training. All men with heart murmurs, unless they can be definitely proved to be functional, are ruled out. All men with questionable visual acuity without glasses are ruled out unless their vision is 20/40 or better bilaterally. Venereal disease disqualifies a man on the original examination. If venereal disease is contracted during the course of training, the soldier is immediately removed from parachute training and disqualified. The syphilitic patient who has had what is considered adequate treatment and whose blood and spinal fluid serologic reaction is negative is acceptable. These are not considered cases of active venereal disease. The elimination of these conditions results in between 10 and 15 per cent rejections of all applicants to the Parachute School reaching Fort Benning for training.

Further selection is accomplished through the observations of the stage leaders in noting hesitancy or actual inability to perform some of the preliminary low jumping procedures.

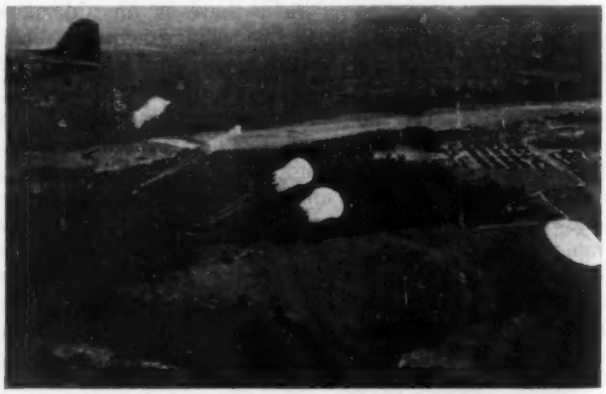

Fig. 10.—Parachutists in various stages of exit from plane. It is at this moment that occasional "freak" accidents occur.

Such selection standards result in the acceptance of the best men available. We are convinced that men physically perfect are less prone to injury in training than those with any physical impairment and therefore accredit some of the diminishing injury rate to the increasing severity of selection standards.

Four typical physical injuries are summarized. These are parachute entities, proved by their repeated occurrence in soldiers taking this course. Their frequency, it is felt, has been much reduced in the past six months, and those occurring now are recognized as incidental to the production of qualified parachutists.

CONCLUSIONS

1. This survey covers parachute descents at the Parachute School in excess of 250,000.

2. Statistically, any parachutist has only 1 per cent chance of injury in any one parachute descent, and this figure is decreasing.

3. Some typical medical parachute entities are now established: (*a*) right rectus muscle strain, (*b*) acromioclavicular contusions and separations, (*c*) fracture of the lower third of the fibula associated with fracture of the posterior tibial lip and (*d*) the "silent fracture" of the upper third of the fibula—and less frequently a dislocation of the fibular head. The fibula can be fractured in its upper third and be relatively asymptomatic; hence the designation "silent fracture."

4. Holding the feet together on contact with the ground, replacing the old method of holding the feet 18 inches apart on landing, has considerably reduced ankle fractures.

Clinical Notes, Suggestions and New Instruments

HEMANGIOMA OF THE KIDNEY

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Fellow in Urology, Mayo Foundation
AND
THOMAS L. POOL, M.D.
ROCHESTER, MINN.

Hemangioma of the kidney is a rare disease. Bell [1] found only 1 instance of hemangioma of the kidney in 30,000 necropsies. In this case the tumor was situated in the substance of the kidney, had not eroded into the renal pelvis and therefore had not caused any symptoms. Judd and Simon [2] in 1928 were able to find only 11 cases of hemangioma of the kidney reported in the literature and added 1 case which they had observed. In 1941 Riley and Swann [3] made a comprehensive review of the literature and were able to collect only 36 authentic cases. They added 1 case which they had observed. Since that time several cases have been reported,[4] but not enough to justify another compilation of collected cases.

Two cases of hemangioma of the kidney have been observed at the Mayo Clinic. One of these cases has been reported by Judd and Simon.[2] The other case will be reported in this paper.

REPORT OF CASE

A man aged 33 was referred to the clinic on May 20, 1941 for routine examination for induction into the Army. He stated that he previously had passed blood in his urine. As urinalysis did not disclose any abnormality and as he had not passed bloody urine for several months, it was felt that he possibly might have essential hematuria.

On April 6, 1943, approximately two years later, the patient was referred to the clinic by his family physician because of an attack of hematuria which had occurred two days previously.

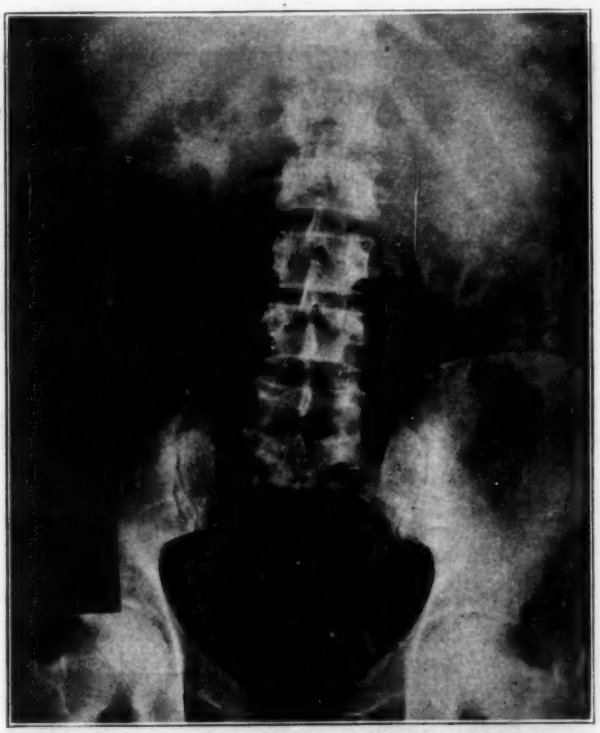


Fig. 1.—Urogram showing failure of left kidney to excrete radiopaque dye.

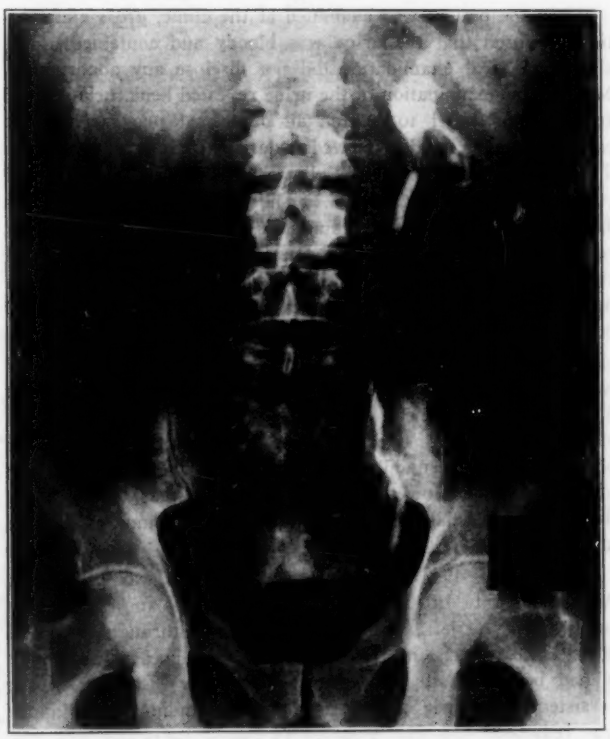


Fig. 2.—Pyelogram made after injection of contrast medium into pelvis of the left kidney.

When the patient was 8 years of age his mother had noticed that his urine was bloody. At the age of 18 years he first had noticed that his urine was bloody. At that time the attack

From the Section on Urology, Mayo Clinic.

1. Bell, E. T.: A Classification of Renal Tumors with Observations on the Frequency of the Various Types, J. Urol. **39**: 238-243 (March) 1938.

2. Judd, E. S., and Simon, H. E.: Angioma of the Kidney, Surg., Gynec. & Obst. **46**: 711-713 (May) 1928.

3. Riley, A., and Swann, W. J., Jr.: Angioma of Kidney, Urol. & Cutan. Rev. **45**: 377-382 (June) 1941.

4. Dean, A. L., and McCarthy, W. D.: Hemangioma of the Kidney Associated with Multiple Hemangiomas, Tr. Am. A. Genito-Urin. Surgeons **33**: 1-9, 1941. McLean, E. H., and Matthews, T. J.: Hemangioma of the Kidney, West. J. Surg. **50**: 47-50 (Jan.) 1942.

of hematuria had been accompanied by dull aching pain in the left flank. The severity of the pain had increased when he passed blood clots. He had been advised to rest in bed for one month. He later had a similar attack in 1932 and again in 1940.

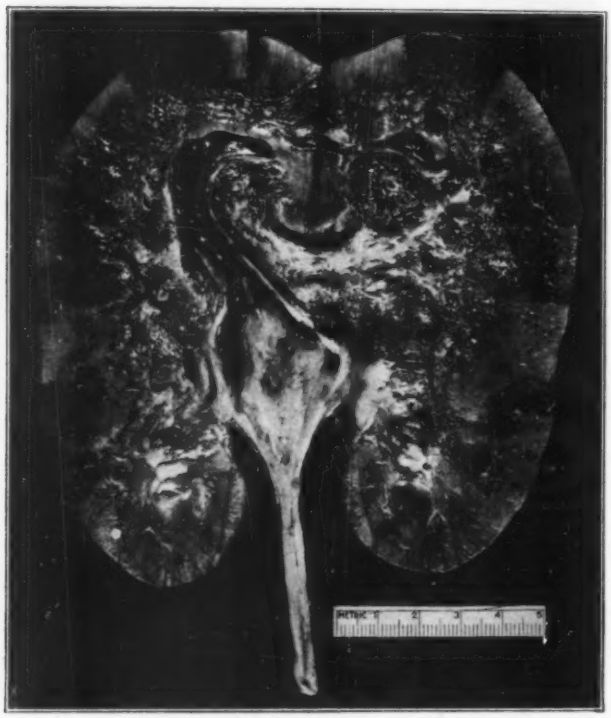


Fig. 3.—Gross appearance of involved kidney.

When the patient was examined at the clinic, gross examination disclosed that the urine was bloody and contained a few clots. Physical examination did not disclose any abnormality. Microscopic examination of the urine revealed hematuria grade 3 (on the basis of 1 to 4) and an occasional pus corpuscle in each microscopic field as viewed under the high power objective. The concentration of hemoglobin was 13.5 Gm. per hundred cubic centimeters of blood. The erythrocyte count was 4,820,000 and the leukocyte count was 6,400 per cubic millimeter respectively. The value for the urea was 40 mg. per hundred cubic centimeters of blood. A serologic test for syphilis was negative, and roentgenographic examination of the thorax did not disclose any abnormality.

Excretory urography revealed that the right kidney probably was normal (fig. 1) although visualization of the contrast medium was indistinct. The left kidney did not excrete any of the radiopaque dye. Retrograde pyelography disclosed obliteration of the middle calix of the left kidney and flaring of the upper and lower calices (fig. 2). It was believed that the patient probably had multiple cysts or a tumor of the left kidney.

On May 13, 1943 an exploratory operation was performed. A combination of spinal and intravenous anesthesia was employed. The left kidney was approached through the usual posterolumbar incision. Grossly the kidney appeared as though it had been the site of repeated infarction. Because of the persistent hematuria and the urographic findings, the kidney was removed.

The kidney measured 13 by 7.5 by 8 cm. and weighed 302 Gm. A diffuse cavernous hemangioma, which measured 9 by 5 by 6 cm., involved the pyramidal portion of the kidney and prolongations of the tumor extended through the cortex to the capsule (fig. 3).

Microscopic examination of the tumor revealed blood vessels and sinuses which varied in size (fig. 4). These were lined with flattened endothelium, and some of them contained erythrocytes and leukocytes.

The renal tissue adjacent to the tumor was the site of chronic inflammation.

Convalescence was uneventful, and the patient was dismissed from the hospital on the twelfth day after the operation.

COMMENT

Hemangioma of the kidney is a rare tumor and its etiologic importance in cases of essential hematuria is not to be emphasized; however, it may be the cause of bleeding of undetermined origin more often than one might suspect, but in the light of Bell's findings this is unlikely. It is, however, a lesion to be remembered in case of essential hematuria and there often is little evidence that one is dealing with such a tumor. Judd and Simon said that this type of tumor rarely was more than 2 cm. in diameter.

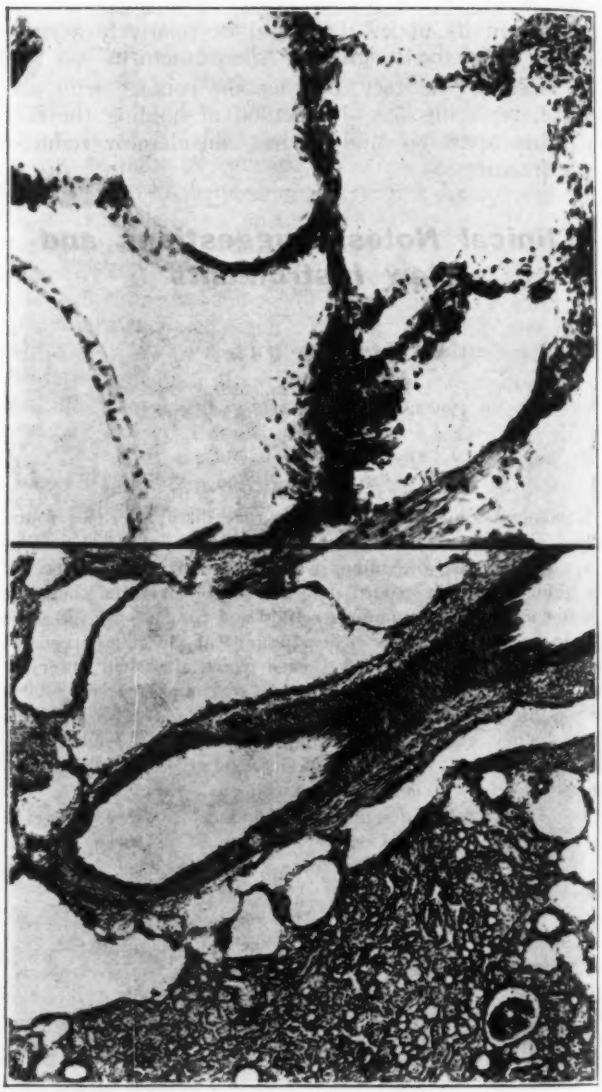


Fig. 4.—Sections of hemangioma of kidney showing difference in size of sinuses and blood vessels (× 40).

The symptoms of hemangioma of the kidney are hematuria, renal colic and the passage of clots. Frequently the bleeding is so profuse that an emergency nephrectomy is indicated. The treatment of this type of tumor consists in removal of the involved kidney.

Council on Physical Medicine

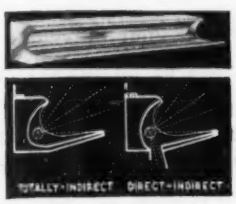
The Council on Physical Medicine has authorized publication of the following report. HOWARD A. CARTER, *Secretary.*

GUTH GERMICIDAL LAMP ACCEPTABLE

Manufacturer of Fixtures: Edwin F. Guth Company, 2615 Washington Avenue, St. Louis.

Manufacturer of Burners: General Electric Company, Lamp Division, Nela Park, Cleveland.

Edwin F. Guth Company presented the following apparatus for Council consideration: (1) the Guth Bracket Unit, (2) Guth Ceiling Unit, (3) Special type of Guth Bracket Unit, (4) Guth Baby-cubicle units and (5) Hospital Operating room unit, all of which are for permanent installation. The firm also submitted (6) floor unit, a standard and de luxe model and another fixture called the (7) "Guth Under-Bed Type," which irradiates the floor.



Guth Germicidal Lamp.

Clinical evidence submitted to the Council on Physical Medicine demonstrates that under properly controlled conditions the killing of air borne micro-organisms by ultraviolet rays may be used to supplement other methods of disinfecting air for prevention of cross infection in contagious wards, in nurseries and for reducing air borne infection of wounds in hospital operating rooms. Council acceptance is limited to ultraviolet disinfecting lamps designed for installation in hospital nurseries, hospital wards and operating rooms.

The General Electric Germicidal Lamps manufactured by the General Electric Company, Lamp Department, Nela Park, Cleveland, have been mounted in fixtures manufactured by the Edwin F. Guth Company. The burner or source of ultraviolet radiation and the several fixtures have been examined by the Council. The characteristics as given for General Electric Germicidal Lamps are presented in the accompanying table.

Characteristics of the General Electric Germicidal Lamps

	G. E. Germicidal 30 Watt	G. E. Germicidal 15 Watt
Glass types	974 glass	974 glass
Lamp watts are ballast	30 + 10	15 + 5
Length in sockets	36 in.	18 in.
Milliwatts, 2,537 angstroms	9,000-10,500	3,600-4,200
Max. Int. Microwatts/cm² 1 m	100-117	40-46
Max. Int. Microwatts/cm² 1 ft	740-840	300-340
Lamp life hours, three hour operating interval	2,500	2,500
Lamp life hours, continuous operation	4,000	4,000

The ultraviolet radiation is confined almost entirely to the wavelength 2,537 angstroms. Fixtures should be designed and installed to insure little or no direct irradiation of the individuals in the rooms.

When first installed the radiant ultraviolet energy is considerably more intense than 20 microwatts per square centimeter at 1 meter, recognized by the Council as being the minimum intensity for acceptance. As the lamps age the intensity drops off rapidly at first and more slowly later on. Under ordinary usage the lamps maintain the acceptable minimum intensity or above for the guaranteed period of four thousand hours of continuous operation. If, however, the lamps fall below this intensity before the guaranteed period has elapsed, the firm will make an adjustment on a pro rata basis. Users of the equipment are advised to test the lamps each month to determine whether they are up to standard. Since the lamps burn at a characteristic color constantly there is no way of determining whether they are emitting sufficient ultraviolet radiation except by testing them with an ultraviolet meter.

Satisfactory evidence is not available to warrant acceptance of ultraviolet lamps for disinfecting solids. To kill a micro-organism a direct hit by ultraviolet rays of sufficient intensity is required. This is difficult to accomplish on the edge of a drinking cup, for example, also in a liquid containing suspended matter or in air laden with dust particles that shield the organism. Ultraviolet radiation cannot penetrate deeply and hence may be absorbed by finger marks, saliva, cosmetics or other foreign matter on a drinking cup. In view of the present available evidence, ultraviolet radiation appears to be an uncertain means of sterilizing solid objects (drinking cups, combs, brushes, shaving utensils, toilet seats and shoes) even if irradiation of the whole surface is possible. Ultraviolet lamps for disinfecting purposes are not accepted for disinfecting air in schools, waiting rooms, public gathering places and large halls. The evidence now available does not indicate that the incidence of colds can be reduced by the installation of ultraviolet lamps or by the irradiation of an enclosure occupied by people.

The Council on Physical Medicine voted to accept the Guth Germicidal lamps for inclusion in its list of accepted devices.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN E. SMITH, M.D., Secretary.

THIAMINE HYDROCHLORIDE (See New and Nonofficial Remedies, 1944, p. 608).

The following dosage form has been accepted:

HORTON & CONVERSE, LOS ANGELES

Tablets Thiamine Hydrochloride: 1 mg.

SULFADIAZINE (See New and Nonofficial Remedies, 1944, p. 178).

The following dosage form has been accepted:

LEDERLE LABORATORIES, INC., PEARL RIVER, N. Y.

Sulfadiazine *(Powder):* 120 Gm. and 453 Gm. packages.

SULFAMERAZINE (See THE JOURNAL, May 6, 1944, p. 31).

The following dosage form has been accepted:

LEDERLE LABORATORIES, INC., PEARL RIVER, N. Y.

Sulfamerazine *(Powder):* 120 Gm. and 453 Gm. packages.

SULFANILAMIDE (See New and Nonofficial Remedies, 1944, p. 184).

The following dosage form has been accepted:

LEDERLE LABORATORIES, INC., PEARL RIVER, N. Y.

Sulfanilamide *(Powder):* 120 Gm. and 453 Gm. packages.

SULFATHIAZOLE (See New and Nonofficial Remedies, 1944, p. 191).

The following dosage form has been accepted:

LEDERLE LABORATORIES, INC., PEARL RIVER, N. Y.

Sulfathiazole *(Powder):* 120 Gm. and 453 Gm. packages.

DIETHYLSTILBESTROL (See New and Nonofficial Remedies, 1944, p. 418).

The following dosage forms have been accepted:

WILLIAM R. WARNER & CO., INC., NEW YORK

Tablets Diethylstilbestrol: 0.1 mg. and 1 mg.

Ampuls Diethylstilbestrol (in oil), 1 mg. per cc.: 1 cc.

Diethylstilbestrol (in oil), 1 mg. per cc.: 10 cc. multiple dose serum capped vials, containing 0.5 per cent chlorobutanol.

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SATURDAY, AUGUST 26, 1944

THE PREVENTION OF CANCER

In a recent and interesting discussion [1] of preventive medicine occurs the statement:

> Prompt and aggressive treatment—a purely curative process—takes on a strongly preventive coloring because it may forestall serious deterioration or death. This is true also of cancer, a nonpreventable disease of unknown cause which can nevertheless be cured in many instances by surgical removal or radiological destruction of the lesion. The full use of modern diagnostic facilities permits such intervention at a profitable stage in many cases of cancer which would otherwise go unrecognized until they were incurable. The gastrointestinal x-ray study which a careful diagnostician orders when confronted with certain abdominal symptoms is thus an important tool of preventive medicine.

Suffering and death from cancer are prevented by its cure and in that respect cancer is preventable. But the remark that cancer is a nonpreventable disease, presumably in the sense that its onset cannot be prevented, and of unknown cause is open to question.

The causes of cancer are by no means unknown. Experiments have demonstrated that a large number of substances can cause cancer. True, the exact mechanism of cancer causation is not understood. Neither do we understand just how the tubercle bacillus causes tuberculosis. Our knowledge of these and other more or less similar mechanisms is as yet mainly in the observational and descriptive stage.

There are many examples of cancer in man that arise under the influence of particular agents under such circumstances that there can be no doubt as to cause and effect. One of these is chimney sweeps' cancer of the skin, recognized by Percival Pott in 1775 as due to the action of soot, from which cancerigenic chemicals have been isolated in recent times. Other examples are mule spinners' cancer, due to mineral oil; cancer of the skin in tar workers; cancer of the lip in fishermen repairing tarred nets; cancer in workers with aniline dyes, and cancer in x-ray and in radium workers. In other cancers the causative condition is obvious but the precise agent is not known. This is the case of cancer at a spot where the mucous membrane of the mouth has been rubbed by a ragged tooth or an ill fitting denture or at the spot on the cheek against which the quid of chewing tobacco has been held perhaps for years. In cattle cancer may arise at the root of the horns where the traction rope runs back and forth. In industries cancerigenic chemicals are used which on entrance into the bodies of workers may cause preventable cancer. The successful results of planned experiments could not be more convincing of the preventability of human cancer than these and other clinical examples. Generally speaking, the association of cancer with chronic inflammatory and irritating lesions—"precancerous conditions"—is so close that their prevention and cure are regarded by physicians as all important measures toward the prevention of cancer. A movement is under way toward the establishment of clinics for cancer prevention. All the efforts to control cancer are based on the possibility of preventing its start as well as its advance.

1. Smith, G., and Evans, L. J.: Preventive Medicine: An Attempt at a Definition, Science **100**: 39 (July 21) 1944.

JAUNDICE FOLLOWING VACCINATION AGAINST YELLOW FEVER

Jaundice occurring in army units stationed largely in this country and associated with vaccination against yellow fever received much publicity about two years ago. Now an exhaustive report has appeared of a study made by a research team appointed by the Surgeon General of the Army to investigate this problem.[1] The report deals with jaundice in army personnel in the western region of the United States and its relation to vaccination against yellow fever.

The greater part of the jaundice which was epidemic in army personnel in the western region of the United States from March to July 1942, it was found, was a hepatitis similar to the common so-called catarrhal jaundice or infectious hepatitis in its manifestations but related to the injection of certain lots of yellow fever vaccines from sixty to one hundred and fifty days before the attacks. The total number of reported cases of jaundice of the type under study in the western region as defined was 11,853, and the records of 10,284 were subjected to statistical analysis. In the latter group there were 31 fatalities, or a mortality rate of 3 per thousand cases. The absence of a noticeable increase in jaundice in navy personnel and in foreign countries where yellow fever vaccines from the same source were used was found to be due to the fact that definitely icterogenic lots of vaccine were not employed in either of those large groups. Although the exact nature of the icterogenic agent in the vaccine could

1. Sawyer, W. A.; Meyer, K. F.; Eaton, M. D.; Bauer, J. H.; Putnam, Persis, and Schwentker, F. F.: Jaundice in Army Personnel in the Western Region of the United States and Its Relation to Vaccination Against Yellow Fever, Am. J. Hyg. **93**: 337 (June), **40**: 35 (July) 1944.

not be determined, the following possibilities were definitely ruled out: that it was due to the modified yellow fever virus in the vaccine, to insanitary conditions, to food or water, to contact with any chemical poison, to inoculation to prevent diseases other than yellow fever or to any local or environmental factor. The most plausible hypothesis as to the source and nature of the agent was that it had been introduced into the vaccine in human blood serums secured from presumably normal donors and that the agent was most probably an unknown filtrable virus capable of causing disease in man and occasionally of circulating subsequently in the blood during a prolonged carrier state. Unfortunately, extensive attempts to isolate the supposed virus agent were either completely negative or gave only suggestive results.

On April 13, 1942, as the result of its first investigations into the subject, the commission's principal recommendation to the Surgeon General of the Army was "That, as far as military exigencies permit, vaccination with lots with numbers over 330 be suspended for at least two months for the purpose of permitting the completion of the investigations in progress and allowing any delayed manifestations to appear and indicate whether later lots are safe. . . ." The final report of the investigative team included the important recommendation that only serum-free yellow fever vaccine be utilized in the immunization of military personnel against yellow fever. That this recommendation was a practical one is due to an extraordinary development: during the course of the investigation the two laboratories which had been preparing the vaccine in the United States devised methods to modify their technic so that human serum could be omitted from a still potent vaccine!

While the problem of jaundice following vaccination against yellow fever may have been completely solved by the removal of human serum from the vaccine, the result of transferring the icterogenic agent may be more difficult to eliminate in other serum-containing biologic products. All possible encouragement and assistance should therefore be given to research aiming to isolate the causative agent of postinoculation jaundice, devising methods for protection and of finding ways of excluding it from all of the serum-containing biologic products.

Prompt and intelligent action here served to place under rapid control an unanticipated complication resulting from the development of a new prophylactic procedure of enormous value. The entire handling of this unexpected mischance reflects great credit on the Office of the Surgeon General of the Army and on all those who took part in the investigations.

MENSTRUAL TOXIN

In 1940 the Smiths [1] of the Free Hospital for Women, Brookline, Mass., tested the toxicity of 37 normal menstrual discharges from parous women. These discharges were often highly toxic for rats. Thirty-five of the thirty-seven specimens produced death within forty-eight hours in 19 to 24 day old female rats, when given twice daily in doses varying from 0.01 to 0.8 cc. The two apparently nontoxic specimens were from the same donor and had been collected during the first day of the menstrual flow. Later specimens from the same donor killed rats in doses varying from 0.1 cc. to as little as 0.01 cc. The most constant lesions found at necropsy in these rats were diffuse or focal hemorrhages of the adrenal cortex with dissolution of cells in either or all zones. In rats that died, early hemorrhage was the only finding. Less constant necropsy findings were hemorrhagic and edematous lesions of the lungs, liver and kidneys, with blood occasionally found in the urinary bladder. With increased length of survival, dissolution to actual necrosis of the parenchymatous cells was also seen. There was usually a brawny induration at the site of the subcutaneous injection.

Male rats and spayed immature females are relatively unsusceptible to this toxin. The susceptibility of normal females varies with the estrous period. Females injected at the beginning of postestrus are most likely to survive. If each dose of the menstrual discharge is accompanied by a subcutaneous injection of 0.05 microgram of estradiol, female rats almost invariably die within forty-eight hours after the first injection, regardless of the time of the cycle. Female rats can be protected against a lethal dose of the toxin, or of the toxin plus estrogen, by preliminary or simultaneous administration of large amounts of progesterone.

Female rats may be immunized against several times the usual minimum lethal dose of the toxin by six biweekly subcutaneous injections of sublethal doses of the toxin, the resulting immunity persisting for at least four months. Mature female rabbits are also extremely susceptible to the discharge, one to three subcutaneous injections of 1 cc. of the menstrual discharge usually resulting in death within forty-eight hours. Rabbits, however, can be immunized by multiple sublethal doses. The serum from such rabbits contains specific precipitins for the toxin. Given in five 1 cc. doses two and a half days prior to the injection of the toxin, this antiserum will protect immature female rats against twice the usual minimum lethal dose of the toxin.

Subsequently these investigators [2] found that when the menstrual discharge is centrifuged a buffy coat or

1. Smith, O. W., and Smith, G. V. S.: Proc. Soc. Exper. Biol. & Med. **44**: 100 (May) 1940.
2. Smith, O. W., and Smith, G. V. S.: Proc. Soc. Exper. Biol. & Med. **55**: 285 (April) 1944.

middle layer of endometrial débris is formed between the serum and the sedimented red blood corpuscles. This layer is ten times more toxic than the supernatant serum. The sedimented blood cells are practically nontoxic. During the catamenial flow the toxicity of different samples varies in direct proportion to the amount of endometrial débris, suggesting that the menstrual toxin is an autolytic product of the decidua menstrualis. This theory is confirmed by repeated failures to produce a similar toxin by the aseptic autolysis of human venous blood or by disintegration of such blood after inoculation with menstrual flora.

After precipitation with one-third saturated ammonium sulfate the toxicity is most concentrated in the water insoluble portion (after dialysis) of the euglobulin precipitate. Further purification of the toxin is hampered by its lability. Partially purified toxin often loses most of its potency while being dried in a Flosdorf-Mudd apparatus. The best preparation thus far obtained was a grayish white powder, killing rats in doses equivalent to 0.75 cc. of menstrual serum. Even the fully dried precipitate rapidly deteriorates, losing three fourths of its toxicity within six weeks.

The nearest approach to the menstrual toxin thus far reported in biochemical literature is the toxic euglobulin in human inflammatory exudate recently described by Menkin,[3] which he named "necrosin." Detailed studies of the relation of "necrosin" to the menstrual toxin are now in progress.

TICK TRANSMISSION OF ENCEPHALITIS

Since the St. Louis epidemic of 1933, many clinicians have assumed that epidemics of acute encephalitis are due to person-to-person droplet infection. The causative agent of the disease, however, has never been isolated from nasopharyngeal washings, and the seasonal variations and topographic distribution strongly suggest an insect vector. Following Syverton's [1] experimental transmission of western type equine encephalomyelitis by means of the wood tick, and the implication of several species of ticks by Soviet investigators,[2] Blattner and Heys [3] of the Department of Pediatrics, Washington University School of Medicine, began a study of the relation of the St. Louis encephalitis virus to the common dog tick (Dermacentor variabilis).

The dog tick is relatively common in the environs of St. Louis and is readily reared under laboratory conditions. Adult females feeding on guinea pigs or hamsters require on an average four to six days for complete engorgement. Four days later eggs are laid. Within fifteen days at ordinary room temperature these eggs develop into typical six legged larvae. Within ten days after an initial blood meal (white mice) the larvae metamorphose into eight legged nymphs. These in turn become eight legged adults in six to eight days after an additional feeding. A blood meal is required before each metamorphosis. If not fed, the tick enters a diapause or latent stage at any stage of development. Under optimum feeding conditions the life cycle may be as short as forty-five to fifty days but may be extended to two years or more under less favorable conditions. The ticks may survive a winter in any stage of development.

Tests with hamsters showed that the virus is present in the blood stream from six hours to seventy-two hours after intraperitoneal inoculation with St. Louis encephalitis. A similar transient virusemia is noted in mice inoculated intracerebrally. Larvae, nymphs and adult ticks were allowed to feed on infected mice or hamsters during the virusemic phase, after which they were transferred to normal white Swiss mice. In nine to fourteen days signs of illness were noted in the second host. With young mice the resulting tick borne infection was usually fatal. Older mice often recovered, eight to twelve weeks later their serums showing the presence of high titer antibodies against St. Louis encephalitis. Many convalescent adults would withstand as much as 10,000 minimum lethal doses of the St. Louis virus injected intracerebrally.

The virus is present in lethal concentration in the eggs of infected female dog ticks and in the larvae, nymphs and adult forms developing from these eggs. It is also present in lethal concentration in the eggs and all stages of development of the second generation. Although the tests have not yet extended beyond the second generation, it seems probable that the virus can be transmitted indefinitely in the progeny of an infected female tick. The virus can remain viable in infected eggs or in the bodies of hereditarily infected ticks which are kept dormant as long as ten months, by storage at 12.5 C.

The St. Louis pediatricians do not believe, however, that the dog tick is the vector responsible for the transmission of St. Louis encephalitis to man, since a history of tick bite was not recorded in the 1933 epidemic. They believe that the dog tick, feeding on birds and mammals, may play an important role in establishing and maintaining a reservoir of infection in nature, from which human beings may be infected by other blood sucking insects. Recent work by Hammon,[4] Howitt [5] and their associates has shown the natural occurrence of St. Louis encephalitis virus in Culex tarsalis and other species of mosquitoes, as well as of type specific

3. Menkin, Valy: Science **97**: 165 (Feb. 12) 1943.
1. Syverton, J. T., and Berry, G. P.: J. Exper. Med. **73**: 507, 1941.
2. New Development in Knowledge of Encephalitis, editorial, J. A. M. A. **117**: 1361 (Oct. 18) 1941; Insect Borne Vaccine, ibid. **119**: 797 (July 4) 1942.
3. Blattner, R. J., and Heys, F. M.: Proc. Soc. Exper. Biol. & Med. **48**: 707, 1941; J. Exper. Med. **79**: 439 (April) 1944.
4. Hammon, W. McD.; Reeves, W. C.; Brookman, B., and Izumi, E. M.: J. Infect. Dis. **70**: 263, 267, 273, 278, 1942; J. Exper. Med. **78**: 241, 1943.
5. Howitt, Beatrice F., and van Herick, William: Proc. Soc. Exper. Biol. & Med. **48**: 247, 1941; J. Immunol. **42**: 117, 1941; Am. J. Pub. Health **32**: 503, 1942.

antibodies in the blood of numerous species of mammals and birds. They have demonstrated experimental transmission of the St. Louis virus to birds by means of bites from nine species of infected mosquitoes.

The work of Blattner and Heys is the first successful transmission of St. Louis encephalitis to experimental animals by means of ticks and is thus a confirmation and extension of work recently reported by Soviet epidemiologists.[2]

Current Comment

POLIOMYELITIS VIRUS IN THE HUMAN OROPHARYNX

Emphasis on the presence of poliomyelitis virus in the feces has tended to retard attempts to isolate the virus from other human sources. Now Howe and his colleagues [1] report on the study of throat swabs taken from 14 cases of acute poliomyelitis during the first week of the disease. Instead of nasal or pharyngeal washings often formerly used, they employed cotton swabs rubbed against the posterior wall of the oropharynx and the peritonsillar area. The swab was then detached, dropped into a fluid tight container with 1 cc. of sterile water and stored on solidified carbon dioxide. The technic of inoculation was as follows: The throat swabs were washed out in phosphate buffer at p_H 8, the fluid being pressed out of the cotton in a syringe. The eluate was then brought to p_H 6 and treated with 20 per cent ether in the ice box until sterile (usually thirty-six hours), at which time the ether was removed. In no case was more than 1.1 cc. of inoculum obtained. Rhesus monkeys of 8 to 10 pounds were inoculated in each lateral thalamus under ether anesthesia. Of the 14 specimens tested (which were unselected from a larger series), 7 produced typical poliomyelitis in the test animals. Six of the 7 animals were paralytic. Microscopic sections showed characteristic lesions in each case. There seems little doubt that the infectious agent was present in the oropharynx and can be definitely transmitted by the technic described.

THE Rh FACTOR IN FEEBLEMINDEDNESS

The importance of the Rh factor in fetal erythroblastosis and in unfavorable reactions in transfusion under certain circumstances is well established. The Rh factor in the blood of a fetus where the father is Rh positive can lead to the production of antibodies in an Rh negative mother, which in turn can destroy red corpuscles in the fetus leading to fetal anemia and its consequences. Now a beginning has been made in the study of the possible relationship of the Rh factor to mental deficiency. Yannet and Lieberman found that, in the case of 53 children with mongolism, birth trauma and other specific types of feeblemindedness, the distribution of the mothers as to Rh positive and Rh negative corresponded closely to the accepted normal white average in the United States. In the case of 56 children with mental deficiencies of unclassified nature, however, 14 of the mothers were Rh negative, which is more than twice the average for the general population. Of these 14 Rh negative mothers 11 had Rh positive children. While the number of cases in this series is too small to have any statistical significance, further study on a much larger scale of the Rh factor in feeblemindedness seems advisable. Commenting on the work of Yannet and Lieberman, Cook [1] points out that destruction of fetal blood cells by anti-Rh bodies in the blood of mothers may lead to serious injury to the fetal brain from anoxia, possibly also in other ways. In fetal erythroblastosis and icterus, degenerative changes in cerebral structures (kernicterus) may occur on a large scale. The idea that the Rh factor may play a role in feeblemindedness turns the attention to the possibility of preventing its disastrous effects. It has been suggested that tests of the blood for anti-Rh agglutinins in pregnant Rh negative women may give warning of the danger of fetal erythroblastosis and thus facilitate appropriate treatment immediately after birth. Further developments of great interest in the understanding of the Rh factor and its effects are foreseen.

INSULIN REQUIREMENT OF MAN AFTER TOTAL PANCREATECTOMY

Complete removal of the pancreas in man should furnish evidence as to the basic insulin requirements: the greatest need should exist when insulin is not produced at all. The truth of this expectation has become a problem of increased clinical importance with the development of modern pancreatic surgery. Observations on two men after total pancreatectomy by Goldner and Clark [1] revealed unexpectedly small insulin requirements and great insulin sensitivity. Pancreatectomy in both cases was performed because of neoplastic growth. During the periods of observation the patients did not receive any nourishment by mouth but were given several blood transfusions and 100 to 150 Gm. of dextrose daily, intravenously, in the form of a 5 per cent solution. One patient also received infusions of casein hydrolysate. Urinalysis and blood sugar estimations were made at regular intervals. A solution of insulin zinc crystals was also added to the dextrose solution and thus entered the system slowly. The first patient excreted 1 to 2 Gm. of dextrose in a urinary volume of 1,500 to 2,000 cc. and the second patient was free at first, becoming anuric later. The first patient received four infusions of 1,000 cc. of 5 per cent dextrose solution within the first thirty-six hours. When the blood sugar had reached 292 mg. per hundred cubic centimeters, 20 units of insulin without dextrose was given. Six hours later a severe hypoglycemic reaction occurred and the blood sugar had dropped to 14 mg. per hundred cubic centimeters. Intravenous injection of 50 Gm. of dextrose resulted in the return of the

1. Howe, Howard A., and others: Poliomyelitis Virus in the Human Oropharynx, Proc. Soc. Exper. Biol. & Med. **56**: 171 (June) 1944.

1. Cook, R.: The Rh Gene as a Cause of Mental Deficiency, J. Heredity **35**: 133 (May) 1944.

1. Goldner, Martin G., and Clark, Dwight E.: The Insulin Requirement of Man After Total Pancreatectomy, J. Clin. Endocrinol. **4**: 194 (May) 1944.

blood sugar level to normal, 127 mg. per hundred cubic centimeters. Insulin was not added to the venoclyses until forty-eight hours later, when the blood sugar had reached 410 mg. per hundred cubic centimeters. The administration of insulin was then resumed, with 5 units. The doses were increased gradually to 10, 15 and 20 units, and no insulin was given without simultaneous dextrose infusion. On this management it was found possible to maintain the blood sugar between 90 and 200 mg. per hundred cubic centimeters and to avoid further hypoglycemic reactions. Thus the daily insulin requirement was only about 50 units on a dextrose intake of 150 to 200 Gm. The course of blood sugar and relation between insulin and hypoglycemia were roughly the same in the second patient. It can be concluded that the depancreatized man requires less insulin and is more sensitive to insulin than many diabetic patients. The question consequently arises as to whether in the causation of diabetes not only lack of insulin but also an insulin inhibiting mechanism may play a part. The line of investigation suggested may throw new significance on the etiology of human diabetes mellitus.

THE NATIONAL FORMULARY MOVES FORWARD

The National Formulary is recognized as an official compendium of certain selected drugs and preparations for the United States. Now the National Formulary is undergoing changes which will effect much improvement. Over 190 drugs, nearly one third of the monographs in N. F. VII, are tentatively slated for deletion from N. F. VIII. Included in these deletions are many preparations that have been obsolete for many years and which at best could never be called truly effective therapeutic agents. Another progressive step is the adoption of English titles in preference to Latin. This change will be hailed by teachers, students and practitioners. Further, the metric system is now used in N. F. monographs, except that doses are given in metric and apothecary systems. The proposed list of additions for N. F. VIII contains a few agents not generally held necessary, but the bulk represent a trend that is most commendable. The National Formulary, United States Pharmacopeia and New and Nonofficial Remedies should be available to every physician.

DANGER OF RABIES INCREASING

Throughout the country the reported increase of rabies in dogs is a cause of mounting concern. Control measures have been instituted in many areas, including parts of southern California, eighteen Michigan counties, St. Louis, the environs of Baltimore and Newport, Ky. Reports from Indiana and the Bronx indicate an increase in the number of rabid dogs and of persons bitten by rabid dogs. If still more serious outbreaks are to be forestalled, such well known preventive measures as muzzling, incarceration and destruction of stray animals, and restraining of all owned dogs by leash will doubtless have to be undertaken in many other communities.

EPIDEMIC OF RINGWORM OF THE SCALP IN NEW YORK CITY

An epidemic of tinea capitis in New York City caused by Microsporon audouini and involving several thousand children has been reported as spreading for more than a year. Tinea capitis has become more frequent in many other large cities; an epidemic status, however, is a unique situation for this country. Epidemics of ringworm of the scalp were known in France, where infected children were sent to separate schools. A committee appointed by the Association of Dermatosyphilologists of Greater New York[1] to study this problem suggests the following as possible causes of this epidemic: 1. Decreased maternal care and supervision because mothers are employed in factories and offices. 2. Countrywide change of residence of members of the armed forces and war workers. Infected children are moved from place to place, traveling with their parents to new locales. 3. Overcrowding in children's institutions and a rapid turnover in these institutions. Inefficient supervision, partly because of lack of personnel and equipment. Infected children may have been known to be discharged to their homes from state institutions. 4. Possibility of spread of the infection through the medium of barber shops and moving picture houses, the backs of subway seats, and other inanimate contacts. Infected hairs have been found in an East Harlem moving picture house. There is no evidence of increased pathogenicity of M. audouini from limited animal experimentation and tests with trichophytin. The first diagnostic center to study the extent of the infection, to assist in diagnosis and to advise practitioners was established in the Astoria health district, where an unusual number of children with infected scalps was reported. All children attending school were examined under filtered ultraviolet rays (Wood light). Infected children were treated with x-rays. After the patient was considered cured by the clinic or doctor, two consecutive negative examinations by the diagnostic center, a week apart, were required before the child could return to school. Based on the Astoria demonstration, the committee made the following recommendations for the control of the epidemic in New York City: 1. Case finding: Tinea capitis should be made a reportable disease; as a preliminary step to control, it is essential to make a citywide case finding survey of all school children, using filtered ultraviolet rays; the case finding survey should be reported every three months; when cases are found, a district diagnostic center should be set up. 2. Education of the public: The public should be reached through the press, from pamphlets and by the radio. 3. Institutions. It is recommended that citywide, complete and periodic inspection of children who are in institutions be made by qualified physicians. Infections caused by Microsporon audouini should promptly receive the benefit of x-ray therapy. Local measures are usually ineffective. Communities free of the disease should take active steps to prevent the disease or to localize any nidus that appears.

1. Lewis, George M.; Silvers, Seymour H.; Cipollaro, Anthony C.; Muskatblit, Emanuel, and Mitchell, Harold H.: Measures to Prevent and Control an Epidemic of Ringworm of the Scalp, New York State J. Med. **44**: 1237 (June 15) 1944.

MEDICINE AND THE WAR

ARMY

HEALTH IN PACIFIC AREAS

[The following is a letter received by Major General Norman T. Kirk from the Honorable Nelson Trusler Johnson, Minister to Australia.]

THE FOREIGN SERVICE
OF THE
UNITED STATES OF AMERICA
AMERICAN LEGATION

Canberra, Australia
June 7, 1944.

Dear General:

I have just returned from a trip in the Pacific areas where American forces are established and working, except for the combat areas. The work which our army medical services have done is so remarkable and so amazingly successful that I felt that I must sit down to write and tell you this.

Certainly these are impossible areas for a white man to live and work in, but I did not see or hear a mosquito the whole time I was there and the records of the various commands and the hospitals show that, through the efficiency of the control planned and carried out in all of these areas, amazing things have been accomplished so that malaria is no longer the threat to success of our mission in this area of war.

I wish I could mention by name all of the officers and men connected with this service I met and saw working, because it is a tribute to each and every one of these men, from the highest to the lowest, that such amazing things have been accomplished in so short a time in a country where, at the beginning of the campaign, it really looked as though the malarial mosquito was going to lick us even before the Japanese got to us.

With kindest regards, I am

Sincerely yours,
NELSON TRUSLER JOHNSON,
Envoy Extraordinary and Minister
Plenipotentiary to Australia.

Major General N. T. Kirk,
Surgeon General,
Army Medical Center,
Washington, D. C.

PLANS IN PROGRESS FOR ARMY MEDICAL HISTORY

At a meeting of representatives of the professional and administrative services of the Office of the Surgeon General, held in Washington, July 26, plans were discussed and progress reports made on the medical history of the war. Work on the history has been in progress since August 1941 under the direction of Col. Albert G. Love, who was a member of the editorial staff that published the history of the Medical Department of the United States Army in World War I. Editors have been selected for the volumes on the medical specialties and the administrative phases of the medical service. In addition to the research and editorial work to be done in the Office of the Surgeon General, historical activities will be carried forward by officers assigned to headquarters of overseas theaters. They will secure first hand reports of the overall medical services, particularly those rendered under combat conditions including evacuation of the wounded, the flow of supplies and other problems. Officers in overseas theaters who have had extensive experience with medical and surgical problems peculiar to this war are being asked to record their observations for the history.

When first organized, historical activities of the Medical Department relative to professional subjects were part of a joint plan to be undertaken in cooperation with the Subcommittee on Historical Records of the Division of Medical Sciences of the National Research Council. The administrative and organizational volumes were to be prepared by the Medical Department. This plan, however, was modified recently in accordance with the wishes of Surg. Gen. Norman T. Kirk. General Kirk felt that the Medical Department should assume full responsibility for its entire history in view of the global scope of the work and the consequent necessity of having the history prepared by officers who have been intimately associated with the practice of military medicine throughout the world.

Medical histories were published by the Office of the Surgeon General following the Civil War and the first world war. The volumes have done much to perpetuate and disseminate professional, administrative and organizational medical advances developed under the impetus of war.

British authorities are carrying forward a similar plan for recording the medical history of the current war.

BRIG. GEN. CHARLES C. HILLMAN IN COMMAND OF LETTERMAN GENERAL HOSPITAL

After five years as chief of the professional service of the Office of the Surgeon General, Brig. Gen. Charles C. Hillman left Washington August 7 to take up his new post as commanding general of the Letterman General Hospital, San Francisco. This hospital, containing 2,500 beds, has been designated as the principal debarkation hospital for casualties from the Pacific area. General Hillman will succeed Brig. Gen. Frank T. Weed, who will soon retire. Major Gen. Norman T. Kirk, Surgeon General, U. S. Army, stated that "General Hillman's assignment as the commanding general of this important hospital on the West Coast illustrates the Army's concern with the care of sick and wounded soldiers. It is of paramount importance that such work be carried out under the direction of a medical man of wide experience and sound judgment. He has ably directed our professional service, being mainly responsible for the initiation of the blood plasma program of the Army, resulting in saving the lives of thousands of American soldiers; under his direction was organized the chest x-ray examination of all Army inductees, with a lowering of the incidence of tuberculosis among military personnel to less than one-tenth that in World War I."

General Hillman graduated from Rush Medical College, Chicago, in 1911. Following his internship in the Cook County Hospital, Chicago, he entered the Army Medical Corps in 1912. His assignments have been largely professional in character in important medical centers of the Army. His service has included several years at tropical stations during the years of peace and inspection of medical services in overseas theaters in the current emergency. In the fall of 1943 he visited Brazil as the official guest of the Brazilian government; following his visit he was decorated in recognition of the assistance that he rendered the medical service of the Brazilian army.

ARMY AWARDS AND COMMENDATIONS

Major John L. Devine Jr.

Major John L. Devine Jr., formerly of Minot, N. D., was recently awarded the Legion of Merit for "exceptionally meritorious conduct in the performance of outstanding service from Sept. 23, 1943 to March 15, 1944." Dr. Devine graduated from Georgetown University School of Medicine, Washington, D. C., in 1937 and entered the service Dec. 12, 1940.

NAVY

NEW EAR PROTECTOR ADOPTED BY NAVY

A new ear protector, called an ear warden, which guards the wearer against the severe noise shocks of gun blasts and the high noise levels of Diesel and airplane engines, has been officially adopted by the Navy. The warden, made of a special compound of neoprene, aids in eliminating ear discomfort and pain and preventing the partial deafness resulting from long exposure to great noise. The device was developed by the University of California at Los Angeles under the direction of the National Defense Research Committee, Office of Scientific Research and Development. Placed on the allowance lists of the Bureau of Ships and the Bureau of Aeronautics, it is now being produced in small quantities and shipped out to the fleet and to naval installations. Bureau of Ships officials express the hope that manufacturers will reach maximum capacity in about three months.

Known officially as the V-51 (R) NDRC Ear Warden, the new device represents extensive research on prevention of damage to hearing from intense sound. Tests give it an insulation index of 113 against 38 for cotton, heretofore used by the Navy, and indexes ranging from 72 to 106 for other types of ear protectors. Its high insulation index will greatly lessen the hazard of partial and temporary deafness resulting from such continuous loud noises as the roar of airplane and PT boat engines and the constant backdrop of sound in engine rooms. Airplane pilots, for example, will be less likely to suffer the permanent hearing loss which is known to flight surgeons as "aviator's notch." This hearing loss, resulting from continued exposure to engine and other noise, is called a "notch" because it represents a small dip in an individual's hearing chart or audiogram in the region of 4,000 sound cycles per second. Not infrequently, long exposure to noise is a factor in permanent deafness.

While a number of other devices which have been in existence plug the ear canal and reduce the transmission of sound, they are not as well engineered acoustically as the Navy approved model, according to tests made by the Harvard University's Research on Sound Control, under the auspices of the National Defense Research Committee. Experiments were made with ten formulas of the synthetic rubber known as neoprene before the final mix was decided on for the warden. The adopted formula is noninflammable, almost as tough and elastic as gum rubber, fully as nontoxic and nonirritating, more free from odor, and more resistant to ear wax, soap and water, and cleaning alcohol. It is also decidedly resistant to sea water. The ear warden also meets other standards set by the Navy. It is easy to insert and remove; it is easy to keep clean; it is comfortable to wear; it is low in cost and feasible to manufacture.

NAVY AWARDS AND COMMENDATIONS

Lieutenant Bothwell Graham III

Lieut. Bothwell Graham III, formerly of Clinton, S. C., was recently awarded a Presidential Unit citation. The presentation was made at Ingram Field, Sampson, N. Y. Dr. Graham, senior medical officer of the Holl Unit dispensary, served as battalion surgeon with the First Marine division in the conquest of the Solomon Islands from Nov. 4, 1942 until Sept. 30, 1943. He entered the Navy on May 26, 1942 and was assigned to the Fifth Defense Battalion, Fleet Marine Force, and in October 1942 participated in the bloodless occupation of the Ellice Islands. He served as assistant battalion surgeon with the Fifth Defense battalion supporting Col. Carlson's Raider's offensive in the eastern landing on Guadalcanal in November 1942 and later served as battalion surgeon with Marine units holding the island of Tulagi. Dr. Graham graduated from the University of Virginia Department of Medicine, Charlottesville, in 1937.

Lieutenant Commander Cyril D. Klaus

Lieut. Comdr. Cyril D. Klaus, formerly of Grand Rapids, Mich., was recently cited by Admiral C. W. Nimitz for his "exceptional devotion to duty on the occasion of his ship receiving a direct hit during an anti-shipping sweep and bombardment. . . . Almost single handedly he administered medical care to nine seriously wounded men. By his skill and professional ability he saved the foot of a petty officer which might otherwise have had to be amputated. During this period he was deprived of the services of his chief pharmacist's mate, who had been seriously wounded. His perseverance and devotion to duty for a long, exhausting period was in keeping with the highest traditions of the naval service." Dr. Klaus graduated from Loyola University School of Medicine, Chicago, in 1932 and entered the service April 1, 1942.

MISCELLANEOUS

WARTIME GRADUATE MEDICAL MEETINGS

The following subjects and speakers for Wartime Graduate Medical Meetings have just been announced:

Station Hospital, Scott Field, Illinois: Chemotherapy, Including Sulfonamides and Penicillin, Dr. R. O. Muether, September 8.

Combined Wartime Graduate Medical Meeting and Meeting of the Kentucky State Medical Association, Lexington, Ky.: Chemotherapeutics in Pediatrics, Dr. John A. Toomey; Chemotherapy (Penicillin), civilian medical essayist, Dr. Donald G. Anderson; Symposium (military essayists): Medical Aspects, Brig. Gen. Hugh Morgan; Surgical Aspects, Col. B. N. Carter; Venereal Disease Treatment, Lieut. Col. Thomas Sternberg; Oration in Medicine, Dr. Frederick G. Speidel; Psychosomatic Medicine, Dr. Maurice Levine; Industrial Health Hazards, Col. Anthony Lanza; Present Status of Pain Relief in Labor, Dr. Frederick H. Falls; Cardiovascular Diseases, Dr. William D. Stroud. Evening session: president's address, Dr. Oscar O. Miller; Accelerated Medicine Today and Tomorrow, Dr. Roger I. Lee; Address, Dr. Edward Henry Cary, September 19.

Symposium on Tropical Diseases: Epidemiology, Dr. R. E. Dyer; Medical Aspects of Tropical Diseases, Capt. Alphonse McMahon; New Weapons for Control of Insect Borne Diseases, Brig. Gen. James S. Simmons; Surgical Aspects of the Chronic Dyspepsias, Dr. Irvin Abell; Oration in Surgery, Dr. J. Farra Van Meter; Arthritis, Dr. Ralph Pemberton; Address, Brig. Gen. Fred W. Rankin; Nutrition—Its Relation to Deficiency Diseases, Col. John D. Youmans, September 20.

At the Station Hospital, Fort Williams, Portland, Maine: Cardiac Neuroses, Cardiac Emergencies, Cardiac Rehabilitation, Drs. Samuel H. Proger and T. Duckett Jones, September 21.

At the Station Hospital, Presque Isle, Maine: The Use of Penicillin and the Sulfa Drugs, Dr. Charles A. Janeway, September 21.

At the Dispensary, U. S. Naval Construction Training Center, Quoddy Village, Maine: The Pneumonias and Other Respiratory Infections, Dr. Cutting B. Favour, September 21.

At the Station Hospital, Fort Banks, Boston: The Skin, Dr. Francis M. Thurman, September 21.

At the U. S. Naval Hospital, Chelsea, Mass.: Acute Infections of the Central Nervous System, Dr. Derek E. Denny-Brown, September 21.

At the Station Hospital and Lovell General Hospital, Fort Devens, Massachusetts: Stomach, Biliary Tract, Intestinal Disorders, Drs. J. Howard Means, Robert R. Linton and Laurence L. Robbins, September 21.

At the Cushing General Hospital, Framingham, Mass.: Peripheral Vascular Disease, Dr. E. Everett O'Neil, September 21.

At the Station Hospital, Camp Myles Standish, Taunton, Mass.: Contagious Diseases and Complications, Dr. Edwin H. Place, September 21.

At the U. S. Marine Hospital, Brighton, Mass.: Blood Dyscrasias and Transfusions, Dr. Louis K. Diamond, September 21.

At the Station Hospital, Westover Field, Chicopee Falls, Mass.: Pilonidal Sinus and Common Diseases of the Anus and Rectum, Dr. E. Parker Hayden, September 21.

At the Dispensary, U. S. Naval Construction Training Center, Davisville, R. I.: Diarrheal Diseases, Drs. Ralph E. Wheeler and Francis C. McDonald, September 21.

At the U. S. Naval Hospital, Newport, R. I.: Cardiac Neuroses, Cardiac Emergencies, Cardiac Rehabilitation, Drs. Paul D. White and Mandel E. Cohen, September 21.

At the Station Hospital, Bradley Field, Windsor Locks, Conn.: Joint Injuries, Dr. John H. T. Sweet Jr. and associates, September 21.

At the Air Corps Station Hospital, New Haven, Conn.: Fractures of Extremities, Dr. Frank S. Jones, September 21.

At the Deshon General Hospital, Butler, Pa.: Tumors of the Testicle, Capt. Reuben B. Gaines, August 31.

HOSPITALS NEEDING INTERNS AND RESIDENTS

The following hospitals have indicated to the Council on Medical Education and Hospitals that they have not completed their house staff quota allotted by the Procurement and Assignment Service:

(Continuation of list in THE JOURNAL August 19, page 1147)

INDIANA

Logansport State Hospital, Logansport. Capacity, 2,395; admissions, 821. Dr. C. L. Williams, Superintendent (residents—psychiatry).

KENTUCKY

Norton Memorial Infirmary, Louisville. Capacity, 165; admissions, 4,840. Mr. Arden E. Hardgrove, Superintendent (2 interns, October 1).

MARYLAND

Maryland General Hospital, Baltimore. Capacity, 294; admissions, 5,217. Mr. Stewart B. Crawford, General Superintendent (resident—gynecology and obstetrics).

NEW JERSEY

Perth Amboy General Hospital, Perth Amboy. Capacity, 197; admissions, 4,729. George C. Shicks, Director (2 interns).

NEW YORK

Beth David Hospital, New York City. Capacity, 187; admissions, 3,985. Mr. Harold M. Salkind, Executive Director (6 interns, October 1).

Yonkers General Hospital, Yonkers. Capacity, 180; admissions, 3,646. Mr. C. E. Croft, Superintendent. (2 interns, October 1; 1 intern, January 1).

NORTH CAROLINA

Charlotte Memorial Hospital, Charlotte. Capacity, 325; admissions, 8,145. Mr. Carl I. Flath, Administrator (residents, October 1).

PENNSYLVANIA

Woman's Homeopathic Hospital, Philadelphia. Capacity, 200; admissions, 2,790. Miss Mary A. Smith, R.N., Superintendent (assistant resident).

WEST VIRGINIA

Wheeling Hospital, Wheeling. Capacity, 255; admissions, 4,870. Sister Mary Ruth, Administrator (intern, October 1).

SURVEY PALESTINE'S HEALTH FACILITIES

Word has recently been received of the safe arrival in Palestine of Rear Admiral Charles S. Stephenson of the United States Navy, who flew to that country on a mission for Hadassah, the Women's Zionist Organization of America. Admiral Stephenson, who headed the American Typhus Commission when it toured the Middle East for the United States government last year, was asked by Hadassah to make a survey of its health institutions and services in Palestine and to chart the probable future health needs of that country. Hadassah felt that such a survey was needed immediately in order to lay the groundwork for the vastly expanded health program it contemplates to prepare Palestine to deal with the health needs of the Jewish refugees, who are expected to reach there shortly in large numbers. The work of medical rehabilitation for the Nazi war victims is expected to be so vast and complex as to require a detailed blueprinting in advance by an expert in the public health field. The large network of medical services in Palestine, both curative and preventive, is directed by Hadassah's representatives in Palestine with funds raised in more than five hundred local chapters throughout the United States.

PUBLIC HEALTH UNDER HITLER

The *Deutsche allgemeine Zeitung* of April 21 (Germany) states that, according to Professor Bockhacker of the Health Office of the DAF, the reduced number of doctors at the beginning of the war made necessary a large scale rationalization of health services. This was made easier by making use of the services of a number of foreign doctors and also by the exceptionally high standard of training of auxiliary medical personnel, especially in spheres in which in peacetime the help rendered by the doctors was more or less mechanical. One measure to intensify the valuable work of the doctor was to reduce private consultations to a minimum by sending the doctor into the factory. It is in the factories in particular that the work of the auxiliary medical staff has been highly effective. They can conduct x-ray examinations and make urine tests without calling on the time of the works doctor. Using these methods has been highly effective. It has been possible to evolve systems under which one doctor can cope with the preliminary work of fifty to sixty assistants.

Bockhacker refutes the widely held opinion that it is possible to assess the working capacity of the worker by means of some onesided examination of output. Experiments of this sort, made among others by the wehrmacht, have meanwhile been abandoned. Psychotechnical methods are never good enough, as they can never fully take the character of the individual into account. In conclusion, Bockhacker declares that war with its hard demands is promoting a natural process of selection. Whereas in the old days social measures helped the weak as well as the strong, today only the strong and the healthy can stand the pace.

According to Zora of March 15, 1944 (Bulgaria) the Chief Public Health Directorate announced that the following new cases of infectious diseases were registered during the week of March 10 to 15: scarlet fever, 44 new cases against 45 for each of the two preceding weeks; diphtheria, 64 new cases against 96 and 85 for the two preceding weeks; typhoid, paratyphoid and dysentery, sporadic cases only; typhus, 73 new cases in twenty-nine inhabited places. Only 6 of them are Bulgarian. Meningitis, 5 cases; infantile paralysis, 1 case. Five or more cases of the same disease were not registered in any single inhabited place.

Le Nouveau Journal of April 3, 1944 (Belgium) states that the Central Office of Statistics published the following figures: During January 1944 there were 10,289 live births: 5,290 boys and 4,999 girls. During the same month there were 12,385 deaths: 6,413 men and 5,972 women.

The *Nieuwe Rotterdamsche Courant* of April 1, 1944 (Netherlands) publishes details of population statistics for Rotterdam. On Jan. 1, 1944 the population numbered 614,627, on February 1 612,575, and on March 1 the figures were 604,886.

Donauzeitung, Belgrade, of April 9-10, 1944 (Yugoslavia) publishes a survey of the Croat state spas, mentioning *inter alia* that four hundred springs have so far been discovered but that only forty-two are being utilized.

According to the *Völkischer Beobachter* of April 22, 1944 (Yugoslavia) an epidemic of typhoid (typhus) has broken out among the bandits on the Dalmatian island of Vis. It is continuing to spread, owing to the complete lack of doctors and medicines.

The Rumanian Ministry of Health has concluded an agreement with three Bucharest builders for the construction of a sanatorium for tuberculosis, at a cost of about 300 million lei, according to *Donauzeitung,* Belgrade, of April 2.

ORGANIZATION SECTION

WASHINGTON LETTER

(From a Special Correspondent)

Aug. 21, 1944.

Health Programs for Federal Employees

Hearings opening today on the recently introduced bill providing health programs for employees of the federal government represents the latest step in the campaign led by the Department of Agriculture and other federal officials to establish a universal health project for the civil servant. Specifically the bill, introduced by Representative Jennings Randolph (Democrat, West Virginia), who also was named by House Civil Service Committee Chairman Robert Ramspeck (Democrat, Georgia) to be chairman of the subcommittee holding hearings, provides for an allotment of funds to improve the "physical and mental efficiency" of government employees through a definite health program to be carried out in conjunction with the United States Public Health Service. It would provide free treatment of minor injuries and illnesses, free physical examinations and the elimination of health hazards. Slated to testify are representatives of the American Medical Association, the National Association of Manufacturers, the C. I. O., the A. F. L. and many other groups.

Under the Randolph bill, federal departments and agencies would have authority to establish health programs on recommendation of the Civil Service Commission and the U. S. Public Health Service. Health service would be limited, it is stated, to treatment of minor illness except in case of emergencies or of injury or illness sustained on the job; preemployment and periodic examination; referral of employees to private physicians, and extensive health education programs.

Sponsors estimate that the government has made disbursements of $8,000,000 annually in payments to federal employees whose health has collapsed completely, forcing retirement before the normal retirement age. They say that a good health program would have kept most of these people in working condition. Backers also say that greater efficiency will be attained by watching the general physical condition of workers. Suggested as an example of a health program in private industry is that of the Standard Oil Company of New Jersey, which provides rigid examinations when employees are hired, health education and safety programs on the job, and continued, periodic check-ups. Top ranking executives get thorough examinations every ninety days. It is said that a great saving of the money invested in all workers in training and experience has resulted through preventing physical breakdown. In the government it is said that in one agency illness caused an average loss of 10.2 days per employee and if through a health program this could have been improved by at least three days per employee over 246,000 man-days would have been saved in the year. This would be equivalent to the services of 820 full time employees.

Prominent witnesses on the opening day of the hearing were War Manpower Commission Director Paul V. McNutt, Arthur S. Flemming, Civil Service Commissioner, and Dr. Carl Peterson, Secretary of the Council on Industrial Health of the American Medical Association.

The Epidemic of Poliomyelitis

The epidemic of infantile paralysis in the Eastern Seaboard states, which up to August 21 had taken six lives and had a total of 87 cases under treatment in Washington hospitals, has elicited advice from Dr. Betty Huse of the crippled children's service of the Children's Bureau, United States Department of Labor, that poliomyelitis patients may be safely admitted to the general wards of hospitals. She urged immediate hospitalization when the disease is suspected as a means of getting for the victim expert treatment, which can prevent crippling in many cases. "Fear of the disease often is responsible for an unwillingness by the hospital to admit infantile paralysis cases when only ward accommodations are available," Dr. Huse explained, "and sometimes the general fear in the community is responsible for the hospital's stand. Poliomyelitis cases need not be placed in separate wards, although it may be desirable to do so for ease in handling. It is essential that all precautionary measures be taken, particularly the disinfection of all excretions."

Dr. Huse said that there have been indications of an epidemic condition in New York, North Carolina, Kentucky, Virginia, Pennsylvania, Ohio, Indiana and Michigan, which thus far the Southern states, with the exception of the three named, had escaped. The Mountain and Pacific states, the West North Central states and the New England states are relatively "free" of cases of poliomyelitis.

It was pointed out that the Children's Bureau administers social security funds for the care of crippled children, which are being used for the care of poliomyelitis victims. Funds are available through state agencies and, as a matter of policy, care is given under the crippled children's program to those suffering from poliomyelitis without regard to the parent's ability to pay. In other words, it was said, when poliomyelitis strikes, treatment is given.

WOMAN'S AUXILIARY

Georgia

The Woman's Auxiliary to the Medical Association of Georgia recently completed its twentieth year. At the annual meeting it was reported that 155,563 hours were given to war service by the auxiliary members. Concerted effort in the fight against the Wagner-Murray-Dingell bill was also reported in twenty-six counties.

Iowa

At a meeting of the Sioux Mes-Dames in Sioux City recently the Community Center Committee reported excellent progress made on the new project—the Lanham Nursery for children whose mothers are employed. The government supplied the funds to establish the nursery, and the Sioux Mes-Dames give their time and provide the "extras" that are needed.

Virginia

The Woman's Auxiliary to the Medical Society of Virginia reported excellent results in its drive for the Leigh-Hodges-Wright Memorial Fund. This fund was established in 1936 for the purpose of supporting an "auxiliary bed" in the state tuberculosis sanatorium for the use of a physician or a member of his family. Since its inception it has been used to assist the daughter of a physician and a medical student who was stricken one month before receiving his degree at the University of Virginia. The fund was named in honor of the members of the State Advisory Council.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

COLORADO

Fellowships in Psychiatry.—The Colorado Psychopathic Hospital, Denver, has been granted funds by the Commonwealth Fund of New York for fellowship training in psychiatry. These fellowships are for a three year period and carry a stipend for each year. The hospital is now taking applications, and those interested should communicate with Dr. Charles A. Rymer, acting director, Colorado Psychopathic Hospital, 4200 East 9th Avenue, Denver.

State Medical Meeting.—The seventy-fourth annual session of the Colorado State Medical Society will be held at the Shirley-Savoy Hotel, Denver, September 27-29, under the presidency of Dr. George P. Lingenfelter, Denver. Among the out of state speakers will be:

Dr. Warren H. Cole, Chicago, Carcinoma of the Colon.
Dr. Fredrick A. Willius, Rochester, Minn., Variables Concerned in Recovery or Death in Acute Coronary Occlusion.
Dr. Maxwell M. Wintrobe, Salt Lake City, A Physiologic Approach to Blood Dyscrasias and Their Diagnosis.
Dr. Herman L. Kretschmer, President of the American Medical Association, Chicago, Problems in the Management of Infections in the Urinary Tract.

Reuben G. Gustavson, Ph.D., president of the University of Colorado, Boulder, will address the annual banquet Friday on "Place of the Medical School in the Community."

X-Ray Survey Unit Given to State.—On July 18 special ceremonies marked the presentation of Colorado's new chest x-ray survey unit to the state board of health, the acquisition of which completes the first stage of the program recommended by the tuberculosis control committee of the Colorado State Medical Society. The second phase of the program, which was to begin in Denver late in July and in Otero County August 1, is "the employment of photoroentgenographic equipment under the joint auspices of the division of tuberculosis of the state board of health and the Colorado Tuberculosis Association for the purpose of identifying and registering as many as possible of the cases of active progressive tuberculosis in the state of Colorado." While the state medical society has approved the tuberculosis case finding program, the approval of the local county or district medical society will be required before the unit will be operated in any local area.

DELAWARE

State Medical Meeting.—The Medical Society of Delaware will hold its annual meeting in Lewes, September 11-12, under the presidency of Dr. Richard C. Beebe, Lewes. A preliminary program announces the following speakers:

Dr. Stanley Worden, Dover, Tick Fever.
Dr. John H. Foulger, Wilmington, Preventive Medicine.
Dr. George J. Boines, Wilmington, Bone Marrow Transfusion.
Dr. John B. Lownes, Philadelphia, Surgical Treatment for Prostatic Obstruction.
Dr. Harrison F. Flippin, Philadelphia, Penicillin Therapy.
Dr. Norris W. Vaux, Philadelphia, Caudal Analgesia.
Dr. George H. Gehrmann, Wilmington, Industrial Medicine.
Dr. Clayton T. Beecham, Philadelphia, The Early Diagnosis and Management of Gynecologic Cancer.

ILLINOIS

Changes in Health Officers.—Dr. Cyrus P. McRaven, Macomb, has been appointed health director of McDonough and Fulton counties, succeeding the late Dr. Edward L. Hill Jr., Mount Sterling.

Chicago

Personal.—Dr. John J. Madden, assistant psychiatrist at the Cook County Psychopathic Hospital, has been named acting superintendent of the hospital during the absence of Dr. Vladimer G. Urse, who has been granted a military leave as superintendent of the hospital.

Searle Plans Expansion Program.—As soon as building restrictions are lifted, G. D. Searle and Company, manufacturer of pharmaceuticals, plans to construct at least one additional building on a recently acquired 5½ acre tract in Skokie which adjoins its present property and on which are located the Searle Research and Manufacturing Laboratories. It is said that the increased research and manufacturing facilities are necessary in view of the continuing rapid expansion of the firm's business, which the present laboratories, completed in March 1942, can no longer accommodate.

Courses in Hospital Administration.—Five courses in hospital administration will be offered in the first semester at Northwestern University beginning September 20. The courses will be on history and development of hospitals, organization and management of hospitals, professional services to the hospital patient, legal, political and sociological aspects of hospital administration, and fundamentals of medical science. Prospective students may apply for admission as candidates for the degrees of bachelor of science in hospital administration or master of hospital administration or as special students. The course in fundamentals of medical science will be open to students who are not registered for other courses in the program in hospital administration as well as to the regular students. The lecturer in the medical science course, which will be offered for the first time, will be Dr. Theodore R. Van Dellen, associate professor of medicine, Northwestern University Medical School. Scholarships are available to selected candidates through funds provided by the American Hospital Supply Corporation and the Johnson and Johnson Research Foundation.

MICHIGAN

Medical Service Returns Loan to State Society.—On July 23 Michigan Medical Service returned to the Michigan State Medical Society the sum of $17,544, which was the amount originally advanced by the latter to assist the medical service as organizational expense in 1939-1940.

Upper Peninsula Meeting.—Dr. Edward Sawbridge, Stephenson, was chosen president-elect of the Upper Peninsula Medical Society at its annual meeting in Houghton, July 27, and Dr. Nathan J. Frenn, Bark River, was installed as president. Escanaba was chosen as the place for the 1945 meeting. Among the speakers at the meeting were Drs. Norman F. Miller, Ann Arbor, on "Diagnosis and Management of Cervical Carcinoma"; Edward L. Tuohy, Duluth, Minn., "Differential Diagnosis of Liver Diseases," and Walter C. Alvarez, Rochester, Minn., "Hints in the Recognition of Neuroses."

Appointments at Michigan.—Dr. James L. Wilson, professor of pediatrics, New York University College of Medicine, has been appointed professor and chairman of the department of pediatrics and communicable diseases at the University of Michigan Medical School, Ann Arbor, effective October 15, and Dr. William Dodd Robinson, formerly of Vanderbilt University School of Medicine, Nashville, Tenn., has been appointed assistant professor in the department of internal medicine and director of the Rackham Arthritis Research Unit, effective September 1. Gordon K. Moe, Ph.D., instructor in pharmacology, Harvard Medical School, Boston, has been named assistant professor in the department of pharmacology, effective August 1.

Changes in Health Officers.—Dr. Clement E. Lockwood, Holly, has been appointed director of the Alger-Schoolcraft District Health Department, succeeding Dr. Henry H. Asher, who died recently.——Dr. Robert E. Flood, Northport, has been appointed health officer of St. Joseph County, succeeding Dr. Frederick A. Musacchio (THE JOURNAL, May 20, p. 220), who resigned to accept a similar position in Texas.——Dr. Sidney I. Franklin, Newberry, has resigned as director of the Luce-Mackinac County Board of Health.——Dr. Willard G. Beattie has been named health officer of Ferndale.——Dr. Leonard C. Bate, Stambaugh, has resigned as director of the Iron-Ontonagon County Health Department, effective August 15, to enter private industrial practice.——Dr. Neal J. McCann has resigned as health officer of Ishpeming.——Dr. Hugh B. Robins has been appointed health officer of the city-county health department in Battle Creek. Dr. Awra A. Hoyt, who served as health officer of Battle Creek for twenty-four years, resigned recently.

NEW JERSEY

New Officers of State Health Board.—Dr. Martin H. Collier, Grenloch, was elected president of the New Jersey State Department of Health at a meeting in Trenton, July 11. Clarence J. Schweikhardt, D.D.S., Maplewood, is vice president. New members of the board are Dr. Frederick P. Lee, Paterson, and Mr. Thomas L. Lawrence, Hamburg.

Personal.—Robert P. Fischelis, Sc.D., has resigned as secretary of the New Jersey Board of Pharmacy, a position he has held since 1926, to devote full time to his work as chief chemist of the drugs and health supplies branch, office of

civilian requirements of the War Production Board, Washington, D. C. Temporarily he will continue to live in Trenton and will continue to serve as president of the New Jersey Pharmaceutical Association. Mr. Adolph V. Palumbo, a member of the state board of pharmacy since 1938, will succeed Dr. Fischelis as secretary of the board.

NEW YORK

Stockton Kimball Named Assistant Dean at Buffalo.—Dr. Stockton Kimball, associate in medicine and pharmacology at the University of Buffalo School of Medicine, Buffalo, on July 15 was appointed assistant dean of the school. Dr. Kimball graduated at the University of Buffalo in 1929 and has been for the past seven years a member of its faculty.

Personal.—Dr. Edith Gardner Mead, member of the Poughkeepsie Board of Health, has been appointed full time medical supervisor of the Poughkeepsie school system to succeed Dr. Helen L. Palliser, whose resignation will become effective on October 1. Dr. Palliser served on a part time basis.——Dr. Herman G. Weiskotten, Syracuse, on July 25 was reappointed a member of the Public Health Council for a term of six years. Dr. Weiskotten, who is dean of the Syracuse University College of Medicine, has been a member of the council since 1936.

New York City

Dr. Moorhead Delays Retirement.—Dr. John J. Moorhead, who was to retire August 1 as medical director of the New York City Transit System, has consented to continue in the position for another year at the request of the board of transportation.

New Department of Medical Films.—A new department of medical films is now available in the New York University Film Library under the supervision of a committee of the New York University College of Medicine. Distribution of the films will be restricted to professional groups and organizations. A series of motion picture films on neuropsychiatric disorders is available to medical and strictly scientific groups for educational purposes by the new department. The films are the work of Dr. S. Philip Goodhart, chief of the neuropsychiatric division, Montefiore Hospital for Chronic Diseases, and professor of clinical neurology, Columbia University College of Physicians and Surgeons, and Major Benjamin H. Balser, M. C. The films have been used for a number of years in courses given to medical students at Columbia and are now made available for teaching purposes and professional discussion groups through the medical department of the New York University Film Library.

Academy of Medicine to Define "Fee Splitting" and "Rebating."—On August 2 the council of the New York Academy of Medicine voted to amend its constitution and by-laws to define more fully the terms "fee splitting" and "rebating" and voted to require applicants for membership to sign the following pledge: "The undersigned hereby agrees to accept the council of the academy as the sole and only judge of his qualifications to remain a fellow." The action is an aftermath of the recent Moreland investigation into "fee splitting" and "rebating" among physicians treating workmen's compensation claimants, which resulted in a number of physicians having their privileges to treat these cases revoked. The academy is reported to have admonished a group of its fellows who were implicated in the charges. In an announcement to the press the academy is reported to have said "The practices referred to are, in the opinion of the academy, entirely contrary to the Hippocratic Oath taken by every physician on receipt of his medical degree; without his signed pledge to avoid such practices no candidate for fellowship can be considered by the academy; and on proof of guilt in such matters, a member is subject to suspension or expulsion from fellowship."

Graduate Courses.—Forty-seven part time courses in widely different branches of medicine, and five full time one week courses will be given for postgraduate physicians by the Mount Sinai Hospital in affiliation with the Columbia University College of Physicians and Surgeons. The courses will begin on September 25 and will be taught by members of the attending staff of Mount Sinai as part of the program of postgraduate medical education of Columbia University. Stress is laid in teaching on diagnosis, treatment and important technical procedures, and courses will include operative demonstrations, clinical conferences and ward rounds as well as lectures. Among the subjects covered in the fall curriculum will be allergy, anesthesia, cardiovascular diseases, electrocardiography, fluoroscopy, gastroenterology, gastroscopy, hematology, diseases of the kidneys and arteries, neurology, electroencephalography, ophthalmology, orthopedics, otology, pediatrics, physical therapy, proctology and tropical medicine. A second series of courses will begin on Feb. 5, 1945. The courses are not intended to train physicians to become specialists but will of interest to physicians who wish to train in laboratory methods as well as bedside instruction. The courses are divided into two groups, those open to all general practitioners and those open only to physicians who have had adequate preliminary training and experience in a related specialty. Application should be made to the Secretary for Medical Instruction, Mount Sinai Hospital, 100th Street and 5th Avenue, New York 29.

OREGON

University News.—Dr. Kenneth C. Swan, research associate in ophthalmology, State University of Iowa College of Medicine, Iowa City, has been appointed associate professor of ophthalmology at the University of Oregon Medical School, Portland.——Dr. L. Everard Napier, director of the Calcutta School of Tropical Medicine in India, lectured at the University of Oregon Medical School July 15 and 17. At the invitation of the National Research Council and under the auspices of the John and Mary R. Markle Foundation, Dr. Napier has been lecturing throughout the country on tropical diseases.

State Medical Meeting.—The Oregon State Medical Society will hold its seventieth annual session at the University of Oregon Medical School, Portland, September 2-3, under the presidency of Dr. Thompson Coberth, The Dalles. The preliminary program includes the following speakers:

Comdr. Jacob J. Enkelis (MC), (subject not announced).
Major George W. Waters, M. C., Fractures of the Elbow Joint.
Capt. Scott H. Goodnight, M. C., Clinical Notes on Malaria.
Capt. Milton Mendlowitz, M. C., Strain of the Pectoralis Minor Muscle as a Cause of Precordial Pain.
Dr. Charles D. Donahue, Eugene, Use of Stilbestrol in Carcinoma of the Prostate.
Dr. Edwin E. Osgood, Portland, Clinical Use of Penicillin.
Dr. John E. Raaf, Portland, Care of the Patient with Acute Spinal Cord Injury.
Dr. Eugene W. Rockey, Portland, Care of Colostomies.
Dr. Raymond R. Staub, Portland, Brucellosis.
Dr. James D. Stewart, Eugene, Subtrochanteric Osteotomy for Nonunion of Hip Fracture.

One of the features of the meeting will be a symposium on "Medical Problems Arising Under the Workmen's Compensation Law and the Occupational Disease Law" by Dr. Douglas G. Cooper, assistant medical director, and Mr. F. I. Brown, claims supervisor, Oregon State Industrial Accident Commission, Salem.

PENNSYLVANIA

State Medical Meeting.—The ninety-fourth annual session of the Medical Society of the State of Pennsylvania will be held at the Hotel William Penn, Pittsburgh, September 19-21, under the presidency of Dr. Augustus S. Kech, Altoona. Included among the guest speakers will be:

Dr. Clyde L. Deming, New Haven, Conn., Acute and Chronic Symptoms and Diagnosis of Movable Kidney; Conservative and Radical Treatment.
Dr. James P. Leake, Bethesda, Md., The Control of Communicable Diseases.
Dr. Emil Novak, Baltimore, Some Misconceptions and Abuses in Gynecologic Organotherapy.
Dr. Ramon Castroviejo, New York, Indications for Keratoplasty and Keratectomies, with Kodachrome Lantern Slides and Motion Pictures.
Dr. Herman E. Pearse Jr., Rochester, N. Y., The Avoidance of Difficulty in Biliary Surgery.
Dr. Earl W. Netherton, Cleveland, Eczema—Management and General Considerations.
Dr. Alexander S. Wiener, New York, Rh Factors and Their Application in Clinical and Legal Medicine.
Dr. Clayton W. Greene, Buffalo, Certain Unusual Clinical Pictures in Renal Disease.

The program also includes a number of Pennsylvania physicians. One feature of the meeting will be a panel discussion on clinical endocrinology by Dr. Edward H. Rynearson, Rochester, Minn., Dr. Charles W. Dunn, Philadelphia, and Dr. Novak.

Philadelphia

Clinics for Early Diagnosis of Cancer.—The International Cancer Research Foundation has established five clinics in Philadelphia to afford periodic physical examinations to discover early symptoms of cancer. Emphasis is placed on prevention of the disease, and the clinics are for both men and women. The clinics are located at the Temple University Hospital, Woman's Medical College of Philadelphia, Jefferson Medical College, Hospital of the University of Pennsylvania, and Hahnemann Hospital, according to the Temple University *News Letter*.

UTAH

Appointments at Utah.—Dr. Francis D. Gunn, associate professor of pathology, Northwestern University Medical School, Chicago, has been appointed professor and head of the department of pathology at the University of Utah School of Medicine, Salt Lake City, effective September 1, according to the *Deseret News*, July 15. Dr. Charles E. McLennan, assistant professor of obstetrics and gynecology, University of Minnesota Medical School, Minneapolis, has been appointed professor and head of the department of obstetrics and gynecology at the University of Utah. Plans were also announced to construct an animal laboratory building. The graduation of the first fourth year class at the medical school will be held September 12.

WISCONSIN

State Medical Meeting in Milwaukee.—The one hundred and third annual session of the State Medical Society of Wisconsin will be held in Milwaukee, September 18-20, under the presidency of Dr. Russell M. Kurten, Racine. A preliminary program lists the following out of state speakers, among others:

Dr. Wallace E. Herrell, Rochester, Minn., Penicillin Therapy.
Dr. James G. Carr, Chicago, Cardiac Traumatism.
Dr. Curtis J. Lund, Minneapolis, Nutrition in Pregnancy.
Dr. Sumner L. S. Koch, Chicago, Treatment of Burns.
Dr. T. Duckett Jones, Boston, Prevention and Treatment of Rheumatic Fever.
Dr. William A. Thomas, Chicago, Histoplasmosis with Diagnosis Made from Multiple Cutaneous Lesions.
Dr. Owen H. Wangensteen, Minneapolis, Ulcer Problem.
Dr. Emil D. W. Hauser, Chicago, Low Back Pain Due to Functional Decompensation of the Back.
Dr. Samuel W. Donaldson, Ann Arbor, Mich., Professional Bureau of the College of Radiology and Its Relationship to Hospitals.
Dr. Edward A. Oliver, Chicago, The Eczematous Dermatoses.
Dr. Loyal Davis, Chicago, Surgery in the Soviet Union.
Dr. Morris Fishbein, Editor of THE JOURNAL, Chicago, Postwar Planning for Medical Services.
Dr. Newell C. Gilbert, Chicago, Physiologic Conditions to Be Considered in Coronary Heart Disease.
Dr. Bayard T. Horton, Rochester, Clinical Use of Histamine.
Dr. M. Edward Davis, Chicago, Modern Management of the Third Stage of Labor and Its Complications.
Dr. Henry L. Williams, Rochester, Chemotherapy in Otolaryngology.
Dr. Avery D. Prangen, Rochester, Surgical Treatment of the Extraocular Muscles—Some Suggestions.
Lieut. Col. James E. Ash, M. C., curator, Army Medical Museum, Washington, D. C., Epibulbar Tumors.
Dr. John A. Toomey, Cleveland, Present Status of the Early Treatment of Poliomyelitis.
Lieut. Comdr. James P. Conway (MC), A Study of the Spread of Streptococcal Disease.

On Tuesday morning, September 19, Dr. Winfred Overholser, professor of psychiatry, George Washington University School of Medicine, Washington, D. C., will deliver the Theresa Lemberg Rogers Memorial Lecture on "Psychiatric Problems in the Aged." Obstetric manikin demonstrations will be conducted by Drs. Davis, Lawrence M. Randall, Rochester, and Russell J. Moe, Duluth. Other features during the meeting will include round table luncheons, the secretaries' conference and motion pictures. Entertainment will be provided at the smoker by Drs. Leander J. VanHecke, Milwaukee, and Emmett T. Ackerman, Muscoda, and his wife.

GENERAL

Mary Beard Resigns from Red Cross.—Miss Mary Beard for a number of years director of the American Red Cross nursing service, has resigned for reasons of health. Her successor is Miss Virginia M. Dunbar, who has been serving as deputy to Miss Beard.

Special Society Elections.—Dr. Clarence G. Salsbury, medical director of Sage Memorial Hospital, Ganado, Ariz., was chosen president-elect of the Association of Western Hospitals at its annual meeting in San Francisco July 5 and Dr. Fred O. Butler, medical director of Sonoma State Home, Eldridge, Calif., was installed as president. Other officers include Mr. Gordon W. Gilbert, administrator of St. Luke's Hospital, Spokane, Wash., and Dr. John C. Sharp, medical director of Monterey County Hospital, Salinas, Calif., vice presidents, and Mr. George U. Wood, superintendent of Peralta Hospital, Oakland, Calif., treasurer.——Dr. Wingate M. Johnson, Winston-Salem, N. C., was elected president of the American Geriatrics Society at its annual session held in New York, June 8-10, and Drs. Walter E. Vest, Huntington, W. Va., and Edward B. Allen, White Plains, N. Y., were chosen vice presidents. Dr. Malford W. Thewlis, Wakefield, R. I., is the secretary and Dr. Richard J. Kraemer, Wickford, R. I., treasurer. The next meeting will be held in New York, June 7-9, 1945.

Contest for Hospital Design.—The Modern Hospital Publishing Company offers six awards in each of two competitions, one for the best designs for a small general hospital and two for the best designs for a small community health center. The competitions are open to any architect, architectural student or draftsman, excepting only those regularly employed by the professional adviser or by the firms or organizations of the judges. Two or more architects or an architect and a hospital administrator, consultant or health officer may work as a team. The first award in both competitions will consist of $1,000. The other awards are $750, $500 and three of $100. The competition is offered to encourage the building, in areas where they are needed, of small hospitals that are efficiently arranged, suitable for smaller communities, creditable in architecture, simple in design, in good taste, economical to build, to operate and to expand and that make maximum use of the best ideas in planning and construction; to furnish to the trustees of small hospitals ideas that will stimulate them to provide better accommodations, and to encourage architects to give more attention to the designing of good small hospitals and community health centers. The judges are Dr. Malcolm T. MacEachern, associate director, American College of Surgeons; Graham Davis, hospital consultant, W. K. Kellogg Foundation, Battle Creek, Mich.; Dr. Vane M. Hoge, chief, hospital facilities section, U. S. Public Health Service; Mies van der Rohe, professor of architecture, Illinois Institute of Technology, Chicago; Nathaniel A. Owings, Chicago; Henry Shepley, Boston, and Charles Butler, New York, all architects. Additional details may be addressed to the Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11.

Academy of Neurological Surgery.—The seventh annual meeting of the American Academy of Neurological Surgery will be held at the Ashford General Hospital, White Sulphur Springs, W. Va., September 7-9, under the presidency of Dr. A. Earl Walker, Chicago, whose address will be on "Neurological Surgery at the Crossroads." Among other speakers will be:

Capt. Major H. Harris and Major George L. Maltby, M. C., Preliminary Analysis of Lumbar Sympathectomy in the Treatment of Trench Feet.
Lieut. Col. Daniel C. Elkin, M. C., Vascular Injuries.
Major Robert P. Kelly, Jr., M. C., Split Thickness Grafts in the Treatment of Osteomyelitis.
Capt. William C. Ward and Lieut. Frank F. Allbritten Jr., M. C., Presentation of Problems in Peripheral Nerve Surgery.
Dr. Edwin B. Boldrey, San Francisco, Stainless Steel Wire Mesh in the Repair of Skull Defects.
Major M. Barnes Woodhall, M. C., The Fate of Whole Fresh Homogenous Nerve Grafts in Men with Remarks Concerning Frozen Dried Nerve Grafts.
Drs. Arthur R. Elvidge and Hamilton A. Baxter, Montreal, Que., A Modification of the Roger Anderson Splint for Severe Fractures of the Facial Bones Associated with Cranial Fractures.
Col. William J. Bleckwenn, M. C., Observations on Neurosurgery and Neuropsychiatry in the South Pacific Theater.
Drs. Joseph P. Evans and Mark I. Scheinker, Cincinnati, Histologic Studies of the Brain Following Head Trauma and Decerebrate Rigidity Following Head Injury.
Drs. Theodore C. Erickson and Henry M. Suckle, Madison, Wis., Observation on the Scalenus Anticus Syndrome in War Workers.
Lieut. Col. David L. Reeves, M. C., Primary Chronic Coccidioidal Meningitis.
Major George A. Baker, M. C., Eosinophilic Granuloma of the Skull.
Dr. Wallace B. Hamby, Buffalo, Tumors of the Spinal Canal in Childhood.
Lieut. Robert H. Pudenz and Lieut. C. Hunter Shelden, M. C., Ventriculocisternostomy: Report of Four Cases.

On Saturday morning there will be a tour of the hospital and ward rounds with the medical staff of the Ashford General Hospital.

Aero Medical Association.—The sixteenth annual meeting of the Aero Medical Association of the United States will be held at the Jefferson Hotel, St. Louis, September 4-6. Among the speakers will be:

Dr. William R. Stovall, Washington, D. C., Physical Requirements and the Private Flier.
Dr. Wilbur F. Smith, Indianapolis, Impressions of a Field Examiner on Entering the Washington Office.
Malcolm Y. McCormick, M.A., Washington, D. C., Physical Competency and Performancy.
Dr. Louis B. Flexner, Baltimore, The National Research Council's Advisory Committee on Civilian Aviation Medicine.
Dr. Alvan L. Barach, New York, Development of Pulmonary Active Tuberculosis as the Result of Aeroembolism at Simulated Altitude Above 40,000 Feet.
Dr. Meyer H. Halperin, Ross A. McFarland, Ph.D., and J. I. Niven, Ph.D., Boston, Alteration in the Effects of Altitude on Vision by Glucose and Carbon Monoxide.
Dr. Thomas H. Sutherland, Marion, Ohio, The Legal Basis of Medical Safety in Aviation.
Drs. Henry F. Helmholz Jr., J. B. Bateman and Walter M. Boothby, Rochester, Minn., Studies in High Altitude Physiology.
Drs. Charles F. Code, Earl H. Wood and Edward H. Lambert and Edward J. Baldes, Ph.D., Rochester, Studies on the Physiology of Acceleration.
Dr. William R. Rowland, Randolph Field, Texas, Night Blindness in Flying Personnel—Observations on Patients: Studies at the A. A. F. School of Aviation Medicine.

Comdr. Ashton Graybiel (MC) and Lieut. W. B. Clark H-V(S), Pensacola, Fla., Disorientation in Pilots.
Lieut. Joseph L. Lilienthal Jr. (MC), Pensacola, The Use of Hyoscine in Air Sickness.
Lieut. Col. F. G. Hall, A. C., Dayton, Ohio, Physiologic Adjustments to High Altitudes.
Lieut. Col. A. P. Gagge, A. C., Dayton, Pressure Breathing.
Lieut. Max David Steer, H-V(S), Pensacola, Improvement of Voice Communication in Flight.
Capt. S. R. M. Reynolds, M. C., and Capt. H. Dohrman, M. C., Orlando, Fla., The Role of the Personal Equipment Officer in the A. A. F.
Lieut. Comdr. Kenneth S. Scott (MC) and Lieut. Comdr. Marion T. Martin (MC), Pensacola, Aviation Safety.
Major George H. Hass, M. C., Randolph Field, Relation Between Force, Major Injuries and Aircraft Structure with Suggestions for Safety in Design of Aircraft.
Col. Manford S. White, M. C., Orlando, Medical Training at the A. A. F. School of Applied Tactics.
Lieut. Richard A. Howard, Orlando, Survival Off the Land.
Dr. George R. Harris, Pittsburgh, Physical Fitness.

Incidence of Poliomyelitis.—In the first thirty-one weeks of 1944 the United States has had more cases of infantile paralysis reported than at any comparable time shown on the records in twenty-eight years, The National Foundation for Infantile Paralysis announces. Latest figures from the U. S. Public Health Service, showing state reports through August 5, reveal a total of 3,992 cases, the National Foundation said. This is 1,226 cases more than reported for the same period last year, when the nation suffered its third worst poliomyelitis epidemic, and 1,089 cases more than in 1931, when the second worst outbreak was recorded. The records of the worst outbreak in 1916 show there were 6,767 cases by August 1 of that year. In five states where the outbreaks are in epidemic or near epidemic proportions, the total cases reported through Aug. 5, 1944 are higher than those states reported for the entire year of 1943. They are:

State	Through Aug. 5, 1944	Entire Year of 1943
New York	902	692
North Carolina	470	37
Kentucky	377	157
Pennsylvania	284	143
Virginia	205	61

The serious or threatening outbreaks this summer are confined almost entirely to states east of the Mississippi, while last year's were largely west of the river.

States which last year had high rates are now nearly normal:

State	Through Aug. 5, 1944	Comparable Period of 1943
California	196	842
Oklahoma	30	240
Kansas	36	109
Texas	116	685

Mr. Basil O'Connor, president, reported that the National Foundation has sent epidemic aid, either in emergency funds, professional personnel or supplies and equipment, into thirteen affected states. In addition to the five named they are Ohio, Tennessee, Michigan, Mississippi, Indiana, Washington, Oregon and California. Outbreaks in the latter three states earlier his year have now waned.

Dr. Bachmeyer Directs Hospital Service.—Dr. Arthur C. Bachmeyer, director of hospitals of the University of Chicago and associate dean of the university's Division of Biological Sciences, on August 1 was chosen director of study in the two year program to survey American Hospitals and their postwar expansion needs. A recently appointed commission, of which Thomas S. Gates, LL.D., president of the University of Pennsylvania, Philadelphia, is chairman, will carry out the study, which will be financed by a grant of $35,000 each by the Commonwealth Fund of New York, the National Foundation for Infantile Paralysis and the W. K. Kellogg Foundation. The American Hospital Association will make an additional contribution of $15,000 if it becomes necessary. It is hoped that the study will determine the adequacy of distribution of present hospital facilities and the best method for ensuring adequate hospital care and such facilities to all citizens. Members of the committee include:

Charles P. Cooper, New York, president, Presbyterian Hospital, first vice president, American Telephone and Telegraph Company.
Katharine J. Densford, R.N., Minneapolis, director, School of Nursing, University of Minnesota.
Albert W. Dent, New Orleans, president, Dillard University (Flint Goodridge Hospital).
Rt. Rev. Msgr. Thomas O'Dwyer, Los Angeles, director of Catholic Charities, Archdiocese of Los Angeles.
Clinton Golden, Pittsburgh, assistant to the president, United Steelworkers of America.
Dr. Evarts A. Graham, St. Louis, surgeon, past president, American College of Surgeons.
Dr. Wilson L. Halverson, Sacramento, commissioner of health of California.
Herbert Hoover, Stanford University, Calif., trustee, Stanford University (Stanford University Hospital).
Ada Belle McCleery, R.N., Stepping Stone, Geneva, Ill., former superintendent, Evanston Hospital, Ill.
Dr. Leroy M. S. Miner, Boston, professor of clinical oral surgery and dean, Harvard University Dental School, Boston.
Dr. Claude W. Munger, New York, medical director, St. Luke's Hospital.
Clarence Poe, LL.D., Raleigh, N. C., editor, the *Progressive Farmer*.
Dr. Willard C. Rappleye, New York, dean, Columbia University College of Physicians and Surgeons.
Edward L. Ryerson Jr., Chicago, trustee, University of Chicago (University of Chicago Clinics), chairman of the board, Inland Steel Company.
J. Barrye Hall, Farmville, Va., president, Southside Community Hospital.
Frank J. Walter, Denver, administrator, St. Lukes Hospital.
Matthew Woll, Washington, D. C., vice president, American Federation of Labor.

LATIN AMERICA

Health Activities in Latin America.—*Institute of Legal Medicine.*—The Faculty of Medical Sciences of the Central University of Ecuador announces the creation of a permanent Institute of Legal Medicine in connection with the university. Dr. José Cruz Cueva, Pichincha No. 24, Quito, Ecuador, has been appointed secretary of the institute, the objectives of which are to disseminate knowledge in the field of legal medicine, the improvement of its teaching in the universities, scientific investigation and research to furnish a basis for the greater understanding and solution of medicolegal problems in Ecuador, technical cooperation with all agencies and officials engaged in the administration of justice, and the technical reform of the laws dealing with medicolegal problems. Life members of the institute will include the dean of the faculty of medical sciences and the professors of legal medicine, psychiatry, histology and pathologic anatomy, criminology and penal law and toxicology of the Central University of Ecuador.

Hospital News.—A 300 bed hospital is planned in La Paz at a cost of about one million dollars. It will be open only to workmen and their families. The project will be directed by the Caja de Seguro y Ahorro Obrero, the Workmen Health Security Institution and Savings Bank. The town has one larger hospital having accommodations of about 550 beds.

Society News.—According to *Medica*, the second National Congress of Cancer will be held early in March 1945 in Havana under the auspices of the Cuban Society of Cancer. It is planned to open to the public for the first time during the congress the dispensary of the League Against Cancer.—— Dr. Oseas Sampaio was chosen president of the Associacão Piauiense de Medicina, Piauhy, Brazil, recently.

Puerto Rico's Proposed Medical School.—A 600 bed hospital and ten other buildings to be spread over 30 acres of land are included in the general plans for the proposed medical school in Puerto Rico to be established under the auspices of the University of Puerto Rico, San Juan, with an allotment of $500,000 granted by local law to organize the school. The complete cost of the project will ultimately be $4,500,000. It is planned to have a contagious disease hospital in a four story building providing 100 beds; a cancer hospital of the same size, already approved by the Insular Health Department; an ophthalmic institute of the same size; a service building with an electric plant, laundry and other services; a blood bank and other laboratories; a kennel for animals used in experiments; a pharmacy and dentistry school; class room units; a dormitory for nurses; a dormitory and cafeteria for 200 students; a psychiatric hospital, and a school for obstetrics. There would also be recreation facilities. The school would graduate fifty doctors each year.

Health Program in Trinidad.—Two million dollars will be expended in Trinidad in the coming year for the expansion of health services which include the creation of three health centers, in addition to two already in operation, the establishment of twelve rural dispensaries, an educational health campaign, improvement in the Trinidad Leprosarium, employment of additional specialists for hospitals, higher salaries for nurses, and appointment of an officer to supervise hygienic instructions in schools and colleges. Work on the construction of a tuberculosis sanatorium, deferred because of war priorities on building materials, is to begin soon; the anticipated cost will be $1,500,000. As a part of the general program to improve health standards in the British West Indies, courses in hygiene and sanitation in all scholastic curriculums will be included. Plans are also under way to establish a laboratory designed for the research in nutritional problems in the West Indies.

CORRECTION

Antibacterial Action of Penicillin.—In the article on penicillin by Herrell et al., THE JOURNAL, August 12, page 1004, in the column headed "Susceptible Organisms," table 1, the term "Vibrio comma" should be "Clostridium septicum." The term "Vibrio comma" should appear at the bottom of the column headed "Insusceptible Organisms."

Foreign Letters

LONDON

(From Our Regular Correspondent)

July 22, 1944.

Prevention of Fires and Explosions in Operating Theaters

Accidents due to the ignition and explosion of anesthetic vapors led to the setting up of a committee of the Institution of Electrical Engineers to consider the electrical conditions in operating rooms and to design equipment for the elimination of explosives. The cooperation of the Medical Research Council, the British Standards Institution, the Surgical Instrument Manufacturers Association and leading surgeons was obtained and resulted in the formation of the Operating Theaters Electrical Apparatus Committee. During the early part of the war the work was in abeyance, but the prevalence of fatal explosions has led to recommendations which have now been accepted by the Ministry of Health and sent to all hospitals in the form of a warning notice to be posted in operating theaters and anesthetic rooms. The notice states that accidents are usually due to (1) ignition of anesthetic vapor by cautery, surgical diathermy, electrical switches or similar appliances; (2) overheating, short circuiting or breakage of the small electric bulbs, or their conducting wires or leads, used in various forms of endoscopy; (3) generation of static electricity resulting in trolleys, tables, blankets and even the clothing of operating personnel becoming charged with electricity. (Contact with an object of a different electrical potential may produce a spark which ignites an anesthetic vapor. The use of alcohol for cleansing the patient's skin involves similar danger.)

In describing the recommended precautions, the committee points out that hot wire cauteries and surgical diathermy present possibilities of ignition, especially near the patient's face. There is also some danger attending the use of x-ray apparatus, motor driven suction apparatus and electrical equipment for lighting, heating and sterilizing, unless it is kept away from the patient. At least five minutes before any form of cautery or diathermy is to be used, all ignitable anesthetics, such as ether, ethylene, ethyl chloride or cyclopropane, must be removed from the apparatus and a safe agent must be substituted. A simple precaution is to blow air or some safe gas through the anesthetic apparatus before use when diathermy is projected, even under a nonignitable anesthetic. It is not sufficient to turn off the ether tap, as this may not be gas tight. The ether bottle should be removed, and if it must be replaced it should first be rinsed out. The presence of oxygen and/or nitrous oxide, although these are not ignitable, increases the risk of ignition of other gases. Surgical lamps are often used with some form of regulating resister. These are usually made for 2.5 or 3.5 volts. It may be dangerous to increase the voltage beyond this to meet the surgeon's request for more light. All insulated flexible wire connected with surgical lamps should be inspected and renewed. If this is not done, the insulation may become faulty or some of the wire strands may be broken, although the lamp appears to function normally. Technical advice should be obtained on methods to limit the current and voltage to values which greatly reduce the risk of ignition even if a short circuit occurs. Foot switches should be flame proof. Insulated apparatus, such as rubber tired trolleys, can be electrified in various ways—for instance, by drawing a dry blanket or towel across them. All anesthetic and operating instrument tables and all trolleys, if insulated by nonconducting rubber tires, must be fitted with trailing chains which make good contact with the floor. This method is useless when the floor is covered with dry, nonconducting rubber, cork carpet or linoleum. Anesthetists and others should remember that under suitable conditions they themselves may become charged by their own movements, and shoes incorporating "conducting rubber" may be used as a safeguard on conducting floors. The general use of this rubber for tubing and tires would tend to prevent accidents. Under war conditions, it is pointed out, dampening of the floor may have to be adopted instead. The generation of static charges is facilitated by a dry atmosphere. Hence the danger is greater in time of high barometric pressure. Some security may be obtained by slightly dampening face pieces, bags, tubing and floors. If it is necessary to make or unmake metallic unions or carry out similar alterations on anesthetic equipment, all ignitable gases must first be cut off.

Diethylstilbestrol in Cancer of the Breast

At the Section of Radiology of the Royal Society of Medicine the treatment of about 100 cases of advanced cancer of the breast with diethylstilbestrol was discussed. Dr. Frank Ellis said that correspondents in the *British Medical Journal* had drawn attention to this treatment and some radiotherapists therefore decided to try it. Cases of advanced carcinoma of the breast often came for radiotherapy, they reasoned, and if a more effective treatment could be found it was important to know it. Owing to the short period of observation, only preliminary reports could be collected. He described 31 cases, in all of which except 1 the effects of diethylstilbestrol could be noted without any complicating effects of radiation. Some were too advanced for radiotherapy; others were on the waiting list for it; and still others had passed the stage when further irradiation could be useful. The doses of diethylstilbestrol were relatively large unless the patients were intolerant. The average was 15 mg. daily. In some cases, but in none which showed improvement, the administration was followed by nausea and vomiting. Other manifestations were activity of the breasts, with pigmentation, tenderness of the areola and in some cases resumption of menstruation. Eight patients showed improvement; their average age was 67.6 years. Fifteen, with an average age of 53.5 years, became worse under treatment. Two became worse during the administration but improved, both subjectively and objectively, after it was stopped. His conclusion was that diethylstilbestrol might make the malignant condition of a younger woman worse but might have value for an older woman. It produced no improvement in bone metastasis.

Dr. S. B. Adams said that of 10 patients 4 showed improvement, 1 being a woman aged 82. In 3 cases the lesions grew in size during the treatment, though the main lesion shrank. In the first case treatment began in July 1943. Only 1 mg. of diethylstilbestrol was given daily. There was definite improvement. There was originally a deep cancer crater of the breast with diffuse infiltration of the chest wall and skin involvement. This healed, leaving a fibrous scar with two small residual nodules. The liver had enlarged since the treatment started, he said, though whether or not this was due to secondary deposits could not yet be stated.

Dr. Alexander Haddow described 13 cases, several of which had been previously treated surgically or by high voltage x-rays and had shown recurrence. Diethylstilbestrol was given in total doses varying from 75 to 676 mg. over periods of from four to twenty-four weeks. Administration was by mouth or intramuscular injection, sometimes by both. In cases responding to the treatment red lesions tended to show a purplish tinge or pallor. Small skin nodules were flattened and

occasionally disappeared. Larger nodules and masses might undergo partial regression. In these 13 cases there was continued advance of the disease in 9, temporary improvement in 3 and definite and more lasting benefit in 1. Favorable advances were much more likely in the older women, this series also demonstrated.

In the whole series recorded by various observers there were 69 patients under the age of 58, of whom 43 did not improve and none showed spectacular improvement. Of 52 over the age of 58 at least 17 improved and 6 or 7 showed spectacular improvement, amounting in some to complete disappearance of advanced disease. Prof. E. C. Dodds said that in patients over 50 it was important to determine the general systemic effect of estrogen therapy because treatment of disorders of the menopause with synthetic estrogens showed great physical and psychologic effects, and these were likely to influence the general condition of the patient with carcinoma. Professor Dodds expressed surprise at the smallness of the dosage reported by some of the observers. It seemed to him that it would have been worth while to give massive doses, he said, and he was also surprised that more powerful synthetic estrogens than diethylstilbestrol were not tried.

BRAZIL

(From Our Regular Correspondent)

July 8, 1944.

Rabies in Rio de Janeiro

At the last meeting of the Brazilian Society of Hygiene, Dr. J. P. Fontenelle, professor of public health and director of the Division of Health Information of the Rio de Janeiro City Health Department, presented a paper dealing with the rabies situation in the city. After pointing out that, according to Rosenau, human rabies was never registered in Australia, an insular country, and that the disease had been stamped out many years ago in Denmark, Sweden, Norway and the British Isles, Dr. Fontennelle said that the mortality statistics of the large cities of the United States show that the annual death rate from rabies has been at the average level of 0.03 per hundred thousand for an aggregate of more than 35 million population in the last decade. In the city of Buenos Aires, Argentina, the mortality returns for the last five years give a mean annual death rate of 0.04 per hundred thousand for a population of 2.5 million, but in Rosario, Argentina's second city, with a population of a little more than 500,000, the mean annual death rate for the last five years is 0.33 per hundred thousand. As for Brazil, Dr. Fontenelle studied the mortality from rabies for the decade 1933-1942 in nine of the largest cities, the present population of which ranges from 113,000 to 1,980,000. For eight of these cities the mean annual death rate from rabies for this period was as follows: Rio de Janeiro (40 deaths), 0.23 per hundred thousand; São Paulo (28 deaths), 0.23; Recife (28 deaths) 0.21; Salvador (8 deaths) 0.27; Porto Alegre (6 deaths) 0.23; Belo Horizonte (9 deaths) 0.47; Belem (14 deaths), 0.66, and Fortaleza (17 deaths) 1.00.

It is the opinion of the author that the control of rabies in a city like Rio de Janeiro consists mainly in the control of stray dogs, many of which are infected by the disease, which often goes unreported by laymen. During the first half of this year, out of many animals examined, 103 have been recognized as affected by rabies: 98 dogs, 3 cats, 1 monkey and 1 rabbit. Therefore it is really the dog, but usually only the "stray dog," which is a concern to the public health.

Many facilities are being offered to the population for the preventive Pasteur treatment of the victims of dog bites; all the fifteen health centers and ten of the municipal hospitals give free treatment, using the Fermi vaccine prepared at the Public Health Laboratory of the city.

Antirabic Service

In May 1930 the Instituto Pinheiros of São Paulo started an antirabic service with the following procedure:

1. The physician requests the first doses of antirabic vaccine by telegraph or telephone.
2. He receives at once a box with six doses.
3. He completes an information form giving an account of the accident and mails it back to the institute.
4. The institute classifies the severity of the case and makes further periodic remittances of recently prepared vaccine.

In remote towns the institute maintains, preferably in the local hospital in a refrigerator, a number of doses of vaccine valid for four months for the immediate beginning of treatment: These are the so-called antirabic stations, which act as follows:

1. On beginning a treatment, the station notifies the institute.
2. By return mail a fresh box of vaccine is sent to replace the one in use, together with doses for the continuation of the treatment in the case just begun.
3. Whenever the valid limit of a vaccine has expired at a station, immediate replacement is made.

The stations in very remote towns, where communication with the institute is difficult, are in contact with intermediate stations, which receive vaccines of recent preparation every week and which are able to classify the severity of the cases and provide for the continuation of treatments.

From May 1930 to June 30, 1942, 12,073 persons were treated, 695 with a vaccine of the Fermi type, in a 6 per cent suspension, phenolized at 1 per cent; 8,238 with a 5 per cent suspension; 3,140 with a 4 per cent suspension. Results are as follows: real failure, 0; false failure, 0.024 per cent; neuroparalytic accidents, 0.008 per cent; cases of shock characterized by a syncopal state immediately after the injections, passing and without after-effect, 0.19 per cent; cases of badly characterized shock, 0.06 per cent; general reactions, 0.08 per cent. There were 205 antirabic stations on June 30, 1942, 204 stations in Brazil, and 1 in the capital of the republic of Paraguay.

The decentralized service solves the economic side of antirabic vaccination, which is of great importance in a vast country like Brazil, with difficulties in communications, and where salaries are low.

The solution of the economic problem signifies an important social attainment as it gives the benefits of science both to the individual with means, who could leave his home town and stay for weeks under treatment in a town where there is a Pasteur institute, and to persons who could not afford to travel to the place of treatment indicated.

Marriages

Frank Ernest Perron Jr. to Miss Jeannette Benoit, both of Manchester, N. H., in Newton, Mass., recently.

Ashby Turner Richards, Harrisonburg, Va., to Miss Evelyn Rosaline Suter of Staunton, June 14.

Harry Hall Womack Jr., Fort Worth, Texas, to Miss Margaret Harris of Galveston, May 22.

David L. Greenlees, Greensboro, Ala., to Miss Ester Schreckengost of Butler, Pa., July 17.

Louis W. Putzig, Blanchard, Mich., to Miss Vera Stevens of Six Lakes in Dearborn, June 24.

John Tabb Walke to Miss Evelyn Chamblin Murrell, both of Richmond, Va., July 6.

Charles W. Iobst, Emmaus, Pa., to Miss Barbara J. Strobel of Allentown, July 15.

Kenneth P. Knudtson, De Forest, Wis., to Miss Ruth Higdon, May 13.

George Vash to Miss Virginia Evans, both of Hinsdale, Mass., June 28.

Deaths

Frederic Atwood Besley ✠ prominent surgeon and leader in surgical organizations, died August 16, aged 76, in the Victory Memorial Hospital, Waukegan, Ill., following a prostatectomy.

Dr. Besley was born in Waukegan, April 19, 1868. He received his early education at the Chicago Manual Training School. After graduating at Northwestern University Medical School in 1894 he served an internship and residency at Cook County Hospital until 1896. In 1900 he was named professor of surgery at the Postgraduate Medical School, Chicago, a position he held until 1908; for a year in 1901 he held a similar appointment at the Woman's Medical College of Northwestern University. In 1899 he joined the staff of Northwestern as clinical instructor in surgery, subsequently advancing through the years until 1915, when he was made professor of surgery.

During the first world war Dr. Besley served as chief surgeon of the Northwestern University Base Hospital Unit number 12. He was with the English forces soon after the entrance of the United States in the war, later serving with the American forces in France. He was commissioned as a major and was retired with the rank of colonel.

After the war Dr. Besley established in Waukegan the Besley-Waukegan Clinic. He had been a member of the staff of a number of hospitals including Cook County, Wesley Memorial and Mercy hospitals, Chicago, and the Victory Memorial Hospital, Waukegan. He was consultant to the Veterans Administration Facility, Downey.

He was a founder member of the American College of Surgeons in 1913, serving as treasurer from 1926 to 1937, president and member of the board of regents from 1937 to 1938, when he became secretary, a position he held at the time of his death. From 1926 to 1939 he was chairman of the college's committee on industrial medicine and surgery. He was also a founder member of the American Board of Surgery. In 1905, with the late Drs. Franklin H. Martin, Allen B. Kanavel, John Hollister, all deceased, and Dr. William R. Cubbins, Dr. Besley served as a founder member of the editorial board of *Surgery, Gynecology and Obstetrics*, holding active membership on the board since its establishment.

He had been a member of the board of directors and treasurer and executive vice president of the Surgical Publishing Company, a member of the American Surgical Association and of the Chicago Surgical Society, serving the last group early in his career as treasurer and later president. He was also president of the Lake County Medical Society in 1930. In 1941 he was appointed a member of the Commission on Physical Rehabilitation of the Health and Medical Committee of the Federal Security Agency.

Wilbert B. Hinsdale, Ann Arbor, Mich.; Homeopathic Hospital College, Cleveland, 1887; formerly dean and professor of the theory and practice of medicine and clinical medicine at the University of Michigan Homeopathic Medical School; president of the American Institute of Homeopathy in 1913 and the Michigan Academy of Science, Arts and Letters in 1931; member of the American Association for the Advancement of Science and the Michigan State Archaeological Society; had been in charge of the Great Lakes division, University of Michigan Museum of Anthropology; health officer in Ann Arbor for many years and served as a member of the board of education; formerly medical director of the University of Michigan Homeopathic Hospital; for many years member and for five years president of the board of trustees of the Michigan Tuberculosis Sanatorium in Howell; for a long period a member of the board of trustees of the Hiram College, Hiram, Ohio; author of "Primitive Man in Michigan," "The Indians of Washtenaw County," "The First People of Michigan," "Archaeological Atlas of Michigan" and "Distribution of Aboriginal Population of Michigan"; died July 25, aged 93, of arteriosclerosis.

Lawrence Joseph Rhea, Montreal, Que., Canada; Johns Hopkins University School of Medicine, Baltimore, 1906; member of the American Association of Pathologists and Bacteriologists, the Association of American Physicians, International Association of Medical Museums, and the Canadian Medical Association; professor of pathology at McGill University Faculty of Medicine, where he was director of the Pathological Institute; assistant professor of pathology at the Harvard Medical School, Boston, 1912-1913, instructor, 1909-1910, and assistant in pathology, 1908-1909; held the rank of major during World War I, with number three Canadian General Hospital, Royal Canadian Army Medical Corps; formerly resident in pathology at the Peter Bent Brigham Hospital, Boston; director of the pathologic laboratory of the Montreal General Hospital, where he died July 3, aged 67.

Edmund F. Collins ✠ Detroit; Western University Faculty of Medicine, London, Ont., Canada, 1912; a fellow of the American College of Hospital Administrators; life member of the American Hospital Association and Michigan Hospital Association; past president of the Greater Detroit Hospital Council; treasurer and member of the board of trustees of the Michigan Hospital Service; member of the American Congress of Obstetrics and Gynecology; first associated with the Grace Hospital as assistant resident physician in 1916 and held numerous executive positions until his appointment as director in 1937; appointed treasurer of the hospital in 1943; died June 29, aged 55, of coronary thrombosis.

Adolphus William Foertmeyer ✠ Cincinnati; Medical College of Ohio, Cincinnati, 1905; also a pharmacist; assistant professor of psychiatry at the University of Cincinnati College of Medicine; member of the American Psychiatric Association and the Central Neuropsychiatric Association; since January 1942 probate court alienist; for two terms county coroner; formerly federal jail physician; served overseas during World War I; major, medical reserve corps, U. S. Army, not on active duty; on the staffs of St. Mary's, Bethesda, Christ, Jewish, Cincinnati General, Deaconess and Good Samaritan hospitals; died June 24, aged 64.

Stephen Trent Barnett ✠ Atlanta, Ga.; University of Virginia Department of Medicine, Charlottesville, 1896; past president of the Fulton County Medical Society; member of the Southern Medical Association; fellow of the American College of Surgeons; served as assistant to chair, clinical gynecology, Atlanta College of Physicians and Surgeons; professor of obstetrics and clinical gynecology at the Atlanta Medical College from 1907 to 1915; visiting gynecologist at Grady, Emory University, Crawford W. Long Memorial, Georgia Baptist hospitals and St. Joseph's Infirmary; died June 27, aged 73.

John Henry Gilpin, Cheboygan, Mich.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1902; member of the Michigan State Medical Society; served overseas during World War I; formerly Indiana commander of the Veterans of Foreign Wars; at one time deputy health commissioner, health commissioner, secretary of the board of health and school physician in Fort Wayne, Ind.; served as commandant of the Indiana State Soldiers' Home in La Fayette; formerly county coroner; district health officer of Cheboygan, Presque Isle, Montmorency and Alpena counties; died June 22, aged 67.

David Hartin Boyd ✠ Pittsburgh; Harvard Medical School, Boston, 1906; specialist certified by the American Board of Pediatrics, Inc.; associate professor of pediatrics at the University of Pittsburgh School of Medicine; member of the American Academy of Pediatrics; past president of the Pittsburgh Academy of Medicine; served overseas during World War I; attending pediatrician, Allegheny General, Children's and Presbyterian hospitals, Pittsburgh, and the Columbia Hospital, Wilkinsburg; consulting pediatrician, Sewickley Valley Hospital, Sewickley; died July 10, aged 64.

William A. Harris, Spotsylvania, Va.; Medical College of Virginia, Richmond, 1901; member of the Medical Society of Virginia; served three terms in the general assembly as delegate from Fredericksburg and Spotsylvania County; a lieutenant colonel in the medical corps of the U. S. Army during World War I and served in France; served as county coroner, as secretary of the board of public roads and as county health officer; formerly member of the board of visitors of Virginia Polytechnic Institute; died suddenly May 25, aged 66, of coronary thrombosis.

Frederick William Adamson, Lake Worth, Fla.; Northwestern University Medical School, Chicago, 1894; drowned at West Palm Beach, June 21, aged 76.

O. Prescott Bennett, Washington, Ill.; Chicago Homeopathic Medical College, 1889; College of Physicians and Surgeons, Chicago, 1890; represented his township on the Tazewell County board of supervisors from 1928 to 1932, holding chairmanship for one year; served overseas during World War I; chief of staff of Washington Hospital; died June 21, aged 75, of coronary thrombosis.

Nicholas Francis Bray, Springfield, La.; St. Louis College of Physicians and Surgeons, 1908; member of the Louisiana State Medical Society; died June 16, aged 64, of carcinoma of the esophagus caused by injury to the neck received in an automobile accident.

Prentice M. Bristow, Stanton, Texas; University of Tennessee Medical Department, Nashville, 1905; served as city and county health officer; died in the Big Spring Hospital, Big Spring, June 12, aged 66, of carcinoma of the liver.

Ray Callis Bunch ✠ Nashville, Tenn.; Vanderbilt University School of Medicine, Nashville, 1916; on the staffs of the Protestant, Nashville General and Vanderbilt hospitals; died June 22, aged 53, of hypertension.

Garrard Peyton Cherry, Mangum, Okla. (licensed in Texas under the Act of 1907 and in Oklahoma by years of practice); member of the Oklahoma State Medical Association; died May 14, aged 82, of senility.

Thomas J. Costello, Seattle; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1904; formerly on the staff of St. Joseph's Hospital, Lewiston, Idaho; died June 18, aged 68.

Francis William Davis, New York; University of the City of New York Medical Department, New York, 1893; member of the Medical Society of the State of New York; served on the staff of the New York Hospital; died in St. Vincent's Hospital June 12, aged 82, of cerebral thrombosis and diabetic acidosis.

Charles Neilson Denison, Waldoboro, Maine; Long Island College Hospital Brooklyn, 1893; formerly health officer of Cheshire, Conn., and New Hartford, Conn.; served as a member of the staffs of the St. Mary's Hospital, Waterbury, Conn., and Miles Memorial Hospital, Damariscotta; died June 7, aged 73, of cardiac asthma.

Lloyd Byron Dochterman, Williston, N. D.; Detroit College of Medicine, 1900; member of the North Dakota State Medical Association; also a pharmacist; health officer of Williston; served during World War I; member of the library board; on the staffs of the Mercy and Good Samaritan hospitals; died June 6, aged 66, of retroperitoneal hemorrhage.

Willard F. Doolittle ✠ New York; Columbia University College of Physicians and Surgeons, New York, 1902; an Affiliate Fellow of the American Medical Association; died in St. Luke's Hospital June 5, aged 72.

Andrew Francis Downing, Cambridge, Mass.; Harvard Medical School, Boston, 1904; member of the Massachusetts Medical Society; at one time examiner for the Massachusetts Civil Service Commission; served on the staffs of the Boston Dispensary, St. Elizabeth's Hospital and the Massachusetts General Hospital, Boston, and the Cambridge City Hospital; died June 2, aged 66, of chronic myocarditis.

Ralph Orr Early ✠ Oklahoma City, Okla.; Rush Medical College, Chicago, 1901; served during World War I; died in St. Anthony Hospital June 6, aged 64, of cerebral hemorrhage.

Anthony Bartholomew Erlain ✠ Cashtown, Pa.; Laval University Faculty of Medicine, Quebec, Que., Canada, 1929; served during World War I; contract surgeon with the U. S. Army for six months; died in Pittsburgh June 2, aged 45, of coronary occlusion.

Ewing Oliphant Evans, San Antonio, Texas; Kentucky School of Medicine, Louisville, 1892; member of the State Medical Association of Texas; president of the city school board from 1918 to 1922; surgeon for the Mexican International Railroad and the Coahuila and Alamo Coal Companies from 1895 to 1902; died June 8, aged 75, of carcinoma of the colon.

George W. Fletcher, Montrose, Ark.; Memphis (Tenn.) Hospital Medical College, 1896; member of the Arkansas Medical Society; served as president of the Ashley County Medical Society; died May 23, aged 74, of chronic nephritis.

Forrest Henry Frey ✠ Wausau, Wis.; Rush Medical College, Chicago, 1913; past president and secretary of the Marathon County Medical Society; on the staffs of the Wausau Memorial Hospital and St. Mary's Hospital, where he died May 31, aged 55, of cerebral hemorrhage and chronic nephritis.

Otto Albert Gahl, Chicago; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1907; died in the City of Chicago Municipal Tuberculosis Sanitarium, June 16, aged 61, of pulmonary tuberculosis.

Albert Mouzon Gantt, Houston, Texas; Louisville (Ky.) Medical College, 1902; member of the State Medical Association of Texas; at one time on the staff of St. Paul's Sanitarium in Dallas; died June 2, aged 68, of coronary thrombosis.

Arthur Clesson Hagedorn, Gloversville, N. Y.; Albany (N. Y.) Medical College, 1892; member of the Medical Society of the State of New York; for many years coroner of Fulton County; on the staff of the Nathan Littauer Hospital, where he died June 23, aged 75, of coronary occlusion.

Germain B. Hale, West Liberty, Ohio; Chicago Homeopathic Medical College, 1894; served as county coroner; died June 11, aged 71, of duodenal ulcer and hemorrhage.

George Dempster Hamlen, Bayside, N. Y.; University of the City of New York Medical Department, 1890; at one time instructor in obstetrics and gynecology at the Cornell University Medical College and on the staff of the Bellevue Hospital in New York; died June 5, aged 77, of heart disease.

Foster Pierce Harbin, Brunswick, Ga.; Atlanta Medical College, 1914; member of the Medical Association of Georgia; associated with the Glynn County Board of Health, in charge of the mobile health unit; died June 14, aged 55, of dilatation of the heart.

Fleet Hiram Harrison ✠ Imlay, Nev.; Missouri Medical College, St. Louis, 1897; a captain in the medical corps of the U. S. Army during World War I; physician and surgeon for the Southern Pacific Railroad; at one time health officer of Alpine County, Calif.; on the staffs of St. Mary's and Washoe County General hospitals, Reno; died in the Southern Pacific General Hospital, San Francisco, June 16, aged 69, of coronary occlusion.

William Cullen Hawken ✠ Detroit; Detroit College of Medicine and Surgery, 1928; medical examiner for the board of education; on the staffs of the Mount Carmel Hospital, Receiving Hospital, St. Mary's Hospital and the Providence Hospital, where he died June 7, aged 42, of arteriosclerotic hypertension with cerebral edema.

Alexander S. Holden, Ellijay, Ga.; Atlanta Medical College, 1897; died in a hospital in Atlanta April 16, aged 78.

Gregory H. Hovnanian, Chicago; Medico-Chirurgical College of Philadelphia, 1890; died June 9, aged 80, of pulmonary tuberculosis.

Harry Newell Howe ✠ Greenfield, Mass.; Columbia University College of Physicians and Surgeons, New York, 1899; served on the draft medical advisory board during World War I; president of the Franklin District Medical Society, 1916-1917; served on the board of health and as school physician; on the staff of the Franklin County Public Hospital, where he died May 11, aged 72, of coronary thrombosis.

John Franklin Iden, Dresden, Ohio; University of Louisville (Ky.) Medical Department, 1894; member of the Ohio State Medical Association; on the staffs of the Good Samaritan Hospital and the Bethesda Hospital, Zanesville, where he died June 11, aged 75, of chronic myocarditis and generalized arteriosclerotic cardiovascular disease.

Allan Smith Ironside, Haddonfield, N. J.; Hahnemann Medical College and Hospital of Philadelphia, 1889; on the staff of the West Jersey Homeopathic Hospital, Camden; died May 31, aged 76, of chronic myocarditis, toxemia and purulent cystitis.

William Francis James, Honolulu, Hawaii; Medical Department of Tulane University of Louisiana, New Orleans, 1893; honorary member of the Hawaii Territorial Medical Association; veteran of the Spanish-American War; for many years acting assistant surgeon in the U. S. Public Health Service; died May 23, aged 83, of senility.

Paul Lemmer Jenny ✠ Pittsburgh; University of Pittsburgh School of Medicine, 1928; instructor in physical therapy at his alma mater; on the staffs of the Passavant and Elizabeth Steel Magee hospitals; died May 28, aged 43, of cerebral embolism.

Reuel Hammond Jones ✠ New Carlisle, Ohio; Ohio Medical University, Columbus, 1905; died May 17, aged 68, of fibrosarcoma.

Jerome Howard King, Mansfield, Ohio; Cleveland Medical College, Homeopathic, 1894; formerly county coroner; died May 13, aged 74.

Andrew Jackson Kismer, Natchez, Miss.; Memphis (Tenn.) Hospital Medical College, 1910; died June 1, aged 58, of chronic myocarditis and myocardial degeneration.

William Carroll Lindsay, Kellogg, Idaho; Northwestern University Medical School, Chicago, 1910; member of the Idaho State Medical Association; past president of the Shoshone County Medical Society; served as a member of the department of law enforcement; served as health officer of Kellogg; formerly health officer of Shoshone County; on the staff of the Providence Hospital, Wallace, where he died June 4, aged 61, of hemorrhage due to gastric ulcer.

Luther M. Linker, Elmira, Ill.; Louisville (Ky.) Medical College, 1895; died June 14, aged 77, of mucous colitis.

Harold Baughman Miller, Lincoln, Neb.; Jefferson Medical College of Philadelphia, 1890; also a pharmacist; formerly professor of materia medica and therapeutics and electrotherapeutics at the Nebraska College of Medicine; member of the

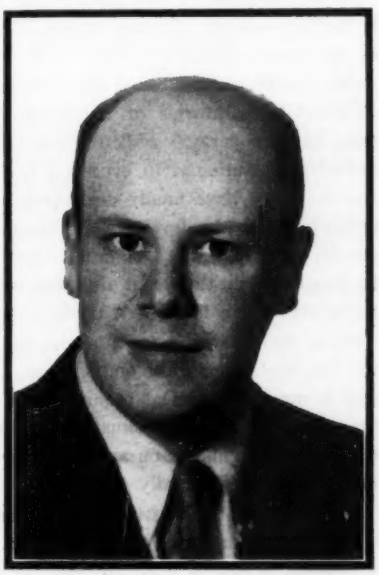
medical staff of the Security Mutual Life Insurance Company; on the staff of St. Elizabeth Hospital, where he died May 22, aged 82, of uremia and renal insufficiency.

Thomas Franklin Petway, Atlanta, Ga.; Atlanta School of Medicine, 1909; member of the Medical Association of Georgia; died in the Crawford W. Long Hospital May 22, aged 65, of acute pyelonephritis.

William A. Repp ✠ Detroit; Detroit College of Medicine, 1895; also a pharmacist; formerly associate professor of gynecology at his alma mater; fellow of the American College of Surgeons; a founder and consulting gynecologist of the Florence Crittenton Home; attending physician and surgeon to St. Vincent Orphan Asylum; chief consultant at St. Mary's Hospital, where he was a member of the staff for more than fifty years and where he died June 19, aged 71, of cardiac thrombosis.

Arthur W. H. Seiple, Larned, Kan.; Southern Homeopathic Medical College, Baltimore, 1898; member of the Kansas Medical Society; died in St. Rose Hospital, Great Bend, May 10, aged 74, of uremia, prostatic obstruction and diabetes mellitus.

Warren Seabury Simmons, Long Island City, N. Y.; College of Physicians and Surgeons, New York, 1892; member of the Medical Society of the State of New York; fellow of the American College of Surgeons; adjunct professor of anatomy at the Long Island College Hospital, Brooklyn, from 1904 to 1914; served on the staffs of the Bushwick, Swedish and St. John's hospitals in Brooklyn; died May 2, aged 77, of heart disease.



LIEUT. (JG) MARTIN H. BRAUN (MC), U.S.N.R., 1914-1943

David English Smith ✠ Bonne Terre, Mo.; Washington University School of Medicine, St. Louis, 1914; Army Medical School, 1917; formerly a major in the medical corps of the U. S. Army; chairman of the staff, Bonne Terre Hospital; died May 5, aged 55.

Robert Thomas Stearns, Scituate, Mass.; Harvard Medical School, Boston, 1902; died April 20, aged 68.

Charles Frank Sullivan, Houston, Texas; Fort Worth School of Medicine, Medical Department of Texas Christian University, Fort Worth, 1918; died May 23, aged 54.

Walter Lee Swindell, Swanquarter, N. C.; Baltimore Medical College, 1908; deputy health officer of Hyde County; physician for the local draft board; died June 12, aged 65, of heart disease.

Theodore Evelyn Townsend, Westwood, N. J.; Long Island College Hospital, Brooklyn, 1891; served as a member of the staff of the Hackensack Hospital, Hackensack, where he died June 18, aged 74, of carcinoma of the pancreas.

Frank Landale Tucker, Brooklyn; College of Physicians and Surgeons, New York, 1891; senior surgeon and formerly member of the board of directors of the Brooklyn Eye and Ear Hospital; died May 28, aged 77, of intradermal carcinoma of the foot.

James Arthur Tucker ✠ Baton Rouge, La.; Medical Department of Tulane University of Louisiana, New Orleans, 1904; for many years attending surgeon to the Louisiana State University and the Louisiana State School for the Deaf; on the staffs of Our Lady of the Lake Sanitarium and Baton Rouge General Hospital; died May 8, aged 65.

Edward Joseph Tulleys, South Salem, Ohio; the Hahnemann Medical College and Hospital, Chicago, 1899; member of the Ohio State Medical Association; on the staff of the Chillicothe Hospital, Chillicothe, where he died June 1, aged 69, of cerebral hemorrhage.

Maud M. Foy Uhl, Glendale, Calif.; University of Buffalo School of Medicine, 1891; died May 2, aged 76, of chronic myocardial degeneration.

McClellan Vance, London, Ohio; Eclectic Medical Institute, Cincinnati, 1887; died May 8, aged 82, of cerebral hemorrhage.

Maurice B. Van Cleave, Terre Haute, Ind.; Hering Medical College, Chicago, 1900; member of the Indiana State Medical Association; past president of the Vigo County Medical Society; served as city health officer; past president of the staff of St. Anthony's Hospital; died June 11, aged 69, of organic heart disease and coronary sclerosis.

Charles Emmett Walker ✠ Sanatorium, Miss.; University of Tennessee College of Medicine, Memphis, 1916; served in France during World War I; assistant superintendent of the Mississippi State Tuberculosis Sanatorium; died June 26, aged 54, of coronary thrombosis.

Robert F. Wells, Manchester, Md.; Baltimore Medical College, 1892; died June 1, aged 78, of peritonitis and gangrene of the cecum.

Betty Whitson, Boise, Idaho; Washington University School of Medicine, St. Louis, 1941; interned at the Flower and Fifth Avenue Hospitals in New York; resident physician at the Medical Center of Jersey City, N. J., where she died May 20, aged 32.

CAPT. HARRY P. SINGLEY, M. C., A. U. S., 1909-1944

Hal Drummond Wilmeth, Barnston, Neb.; Lincoln Medical College, Eclectic, 1916; died in the Veterans Administration Facility, Knoxville, Iowa, May 4, aged 52, of coronary occlusion.

Thomas L. Wilson, Bellwood, Pa.; College of Physicians and Surgeons, Baltimore, 1891; member of the Medical Society of the State of Pennsylvania; for many years Bellwood councilman and medical examiner for Bellwood borough and Antis township schools; died May 7, aged 81, of hypostatic pneumonia.

Manoug Garabet Yardume, Boston; Harvard Medical School, Boston, 1900; served as medical consultant for the John Hancock Insurance Company; associated with the Massachusetts General, Faulkner and Peter Bent Brigham hospitals; died June 19, aged 72, of angina pectoris.

KILLED IN ACTION

Martin Herman Braun, Kew Gardens, N. Y.; Howard University College of Medicine, Washington, D. C., 1940; interned at the Harlem Hospital in New York; commissioned a lieutenant (jg) in the medical corps of the U. S. Naval Reserve on June 12, 1942; aged 29; declared missing in action on Nov. 12, 1942; killed in action in the Atlantic area; presumptive date of death Nov. 13, 1943, according to the Navy Department.

Harry Paul Singley, Ventnor, N. J.; Jefferson Medical College of Philadelphia, 1936; member of the Medical Society of New Jersey; served an internship at the Western Pennsylvania Hospital, Pittsburgh; commissioned a first lieutenant in the medical corps, Army of the United States, on June 13, 1942; later promoted to captain; killed in the invasion of France, June 6, aged 34.

Bureau of Investigation

STIPULATIONS

Agreements Between Federal Trade Commission and Promoters of Various Products

Following are abstracts of stipulations in which promoters of "patent medicines," medical devices and cosmetics have agreed, following action by the Federal Trade Commission, to discontinue certain misrepresentations in their advertising. These stipulations differ from the "Cease and Desist Orders" of the Commission in that such orders definitely direct the discontinuance of misrepresentations. The abstracts that follow are presented primarily to illustrate the effects of the provisions of the Wheeler-Lea Amendment to the Federal Trade Commission Act on the promotion of such products:

Athygienic Foot Powder and Athygienic Foot Glove.—That these products are remedies for corns or foot ailments generally were misrepresentations which the Wilson Industries, Inc., of Chicago agreed to eliminate from their advertising in a stipulation that they entered into with the Federal Trade Commission in October 1943.

Blue Bonnet Mineral Water Crystals.—This product is sold by Zeta M. Pack, trading as Loye Distributing Company, Wheeling, W. Va. In September 1943 this person stipulated with the Federal Trade Commission that she would cease representing that the preparation will correct excess acidity, build up the system, keep the body healthy, or help one to regain good health; that it will increase resistance to colds, grippe and other ailments, insure good appetite or sound sleep or restore energy; that it will be beneficial for conditions of fatigue, listlessness or lack of "pep," or rid the system of, or keep it free from, poisons. She further agreed to discontinue any advertisement which represented that the product is in all cases harmless, or which failed to reveal that it should not be taken by persons suffering from abdominal pain or other symptoms of appendicitis; provided, however, that such advertisements need only contain the statement, "Caution: Use only as directed" if the label instructions for use include a warning to the same effect.

Dar-Sal.—This is a dehydrated product of goat's milk put out by J. F. Darrington, trading as Darrington's, Marshfield, Ore. In September 1943 Darrington stipulated with the Federal Trade Commission to cease representing that Dar-Sal is made by a secret process or possesses unique or special properties which are not present in other dehydrated products of goat's milk; that it has any value when used in connection with the treatment of run-down conditions, nervous disorders, stomach trouble, eczema, asthma, hyperacidity, rheumatism, paralysis or arthritis; that it is a cold preventive or will improve the user's health or build up his resistance to infectious diseases.

Dr. Carolus M. Cobb's Nasal Spray for Sinus Relief.—That this will relieve sinus trouble or the pain of headaches associated therewith, or open the sinus passages, were misrepresentations which Estelle Cobb Brown, East Lynn, Mass., agreed to eliminate from the advertising in a stipulation that she entered into with the Federal Trade Commission in September 1943.

Dr. True's Elixir.—In September 1943 the Federal Trade Commission accepted a stipulation from Dr. J. F. True & Company, Inc., Auburn, Maine, and its advertising agency, the S. A. Conover Company, Boston, in which these concerns agreed to discontinue any advertisement which failed to reveal that the "Elixir" should not be used in the presence of symptoms of appendicitis, such as abdominal pain, nausea or vomiting. The stipulation permitted, however, that such advertisements need contain only the statement, "Caution: Use only as directed" if the same warning were included in the directions on the label. In an earlier case (June 1937) the True concern had stipulated with the Commission that it would no longer advertise that the product was useful in treating ordinary ailments of children, and would safeguard health, gave children double protection, and contained no harmful ingredients.

"My Own Story of My Diabetes."—This is the title of a publication sold by George V. Harnetty, San Diego, Calif. In September 1943 Harnetty stipulated with the Federal Trade Commission to cease representing that by reading this work, a person "can learn a cure for diabetes." He further agreed not to publish or cause to be published any advertisement concerning this publication which would fail to reveal the material fact that the treatment referred to in the advertisement involves the use of a chemical or drug which will have irritant effects and may seriously interfere with the proper functioning of injured or diseased kidneys, and that its prolonged use may injure kidneys that are normal.

Vi-Mins and Vita-Food.—These are two names for one product put out by V. E. Michael of Ashtabula, Ohio. In October 1943 he stipulated with the Federal Trade Commission that he would no longer represent in his advertising that the preparation is the most complete vitamin or mineral product ever offered for sale; that it insures a vigorous personality, a disease-resisting body, good teeth and a clear complexion; that it improves eyesight, relieves fatigue, reduces nervousness and aids digestion; that it prevents sinus trouble, catarrh, headaches, arthritis, rheumatism and ailments of the liver, kidneys and heart, and assists in overcoming excess weight and preventing infection from entering the body.

Correspondence

DUSTING POWDER FOR SURGICAL GLOVES

To the Editor:—In THE JOURNAL, Dec. 11, 1943, in a study of possible substitutes for talcum powder, Verda, Kidd and I stated that potassium bitartrate was a satisfactory dusting powder but that it tended somewhat to shorten the life of rubber gloves. This statement is subject to correction. We found later, after changing the brand of glove we had been using, that there was no determinable deteriorating influence on the life of the glove. We were prompted to investigate this particular phase of the work by a personal communication to us from the Research Laboratory of the Wilson Rubber Company, stating that a very carefully checked set of experiments made by the laboratory failed to reveal any adverse effect of potassium bitartrate on either latex or pure gum rubber gloves.

A second point of importance that we set out in our paper is the impossibility of using starch as a dusting powder because of the gelatinization resulting from the reaction of starch to steam sterilization. Since the publication of our paper, the Research Laboratories of the Corn Products Refining Company have cooperated with us most kindly and most enthusiastically in the attempt to overcome the gelatinizing property of starch. They have finally developed, by the application of new processes, recently developed by them, a special starch dusting powder that does not gelatinize when subjected to boiling or to steam sterilization and that has no deteriorating effect on the gloves. We have been using a sample of this new starch dusting powder for twelve weeks in the operating rooms of the Barnard Free Skin and Cancer Hospital and have found that it meets all clinical requirements. Both the surgeons and the operating room personnel have found it thoroughly satisfactory. Experiments on animals showed this new starch dusting powder to be totally innocuous.

This new starch dusting powder, unfortunately, cannot yet be furnished for general use, because current difficulties with equipment priorities may preclude its manufacture in quantity until after the war. In the meantime we have been receiving such favorable reports concerning the potassium bitartrate powder that we advise its substitution for talcum until such time as the new starch can be produced in quantity. Talcum cannot be removed from the operating room at too early a moment.

M. G. SEELIG, M.D., St. Louis.
Director of pathology, the Barnard
Free Skin and Cancer Hospital.

SULFADIAZINE IN NASOPHARYNGITIS

To the Editor:—Regarding the article "Sulfadiazine in the Treatment of 200 Cases of Acute Catarrhal Nasopharyngitis" by Capt. F. B. Faust and Capt. J. H. Simmons in THE JOURNAL, June 24, page 552, "hospital days" as a determining factor in the response of a disease to a therapeutic agent is an extremely loose one, especially in a station hospital in the Army.

Many patients who would normally be considered cured and discharged are often maintained as patients because of technical or administrative reasons. As a result, statistics solely based on hospital days in an army installation may not be entirely accurate.

Furthermore, it is doubtful that the degree of morbidity of nasopharyngitis can be based solely on the extent of temperature elevations. Many nasopharyngitis patients have acute symptoms and appear severely ill in the presence of normal temperatures or slight elevations above normal.

Even assuming for the sake of argument that hospital days could be accepted as reliable criteria for determining therapeutic results, the only important conclusion that could possibly be reached from the authors' statistics is omitted, viz. that the routine administration of sulfadiazine is without value in the treatment of nasopharyngitis, which fact is generally accepted by most clinicians. This conclusion might be drawn from the following statement from the article in question: "The total hospital days in the series treated with sulfadiazine was 648 days. The total hospital days in the control series was 462 days. The average number of days was 5.6 for both series."

DONALD H. ATLAS, Captain, M. C., A. U. S.
LOUIS R. HOTT, Major, M. C., A. U. S.

Society Proceedings

COMING MEETINGS

Aero Medical Association of the United States, St. Louis, Sept. 4-6. Dr. David S. Brachman, 5440 Cass Ave., Detroit 2, Secretary.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 8-12. Dr. W. L. Benedict, 102 Second Ave. S.W., Rochester, Minn., Secretary.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 7-9. Dr. James R. Bloss, 418 Eleventh St., Huntington, W. Va., Secretary.

American Congress of Physical Therapy, Cleveland, Sept. 6-9. Dr. Richard Kovacs, 2 East 88th St., New York 28, Secretary.

American Hospital Association, Cleveland, Oct. 2-6. Mr. George P. Bugbee, 18 East Division St., Chicago, Executive Secretary.

American Pediatric Society, Atlantic City, N. J., Sept. 25-27. Dr. Hugh McCulloch, 325 N. Euclid Ave., St. Louis 8, Secretary.

American Public Health Association, New York, Oct. 3-5. Dr. Reginald M. Atwater, 1790 Broadway, New York 19, Executive Secretary.

American Roentgen Ray Society, Chicago, Sept. 24-29. Dr. H. Dabney Kerr, University Hospitals, Iowa City, Secretary.

Colorado State Medical Society, Denver, Sept. 27-29. Dr. John S. Bouslog, 537 Republic Bldg., Denver 2, Secretary.

Delaware, Medical Society of, Lewes, Sept. 11-12. Dr. W. O. La Motte, 601 Delaware Avenue, Wilmington, Secretary.

District of Columbia, Medical Society of the, Washington, Oct. 5-7. Mr. Theodore Wiprud, 1718 M St. N.W., Washington, Secretary.

Indiana State Medical Association, Indianapolis, Oct. 3-5. Mr. T. A. Hendricks, 23 East Ohio St., Indianapolis 4, Executive Secretary.

International College of Surgeons, U. S. Chapter, Philadelphia, Oct. 3-5. Dr. Desiderio Roman, 250 South 17th St., Philadelphia, Secretary.

Kentucky State Medical Association, Lexington, September 18-20. Dr. P. E. Blackerby, 620 S. Third St., Louisville, Secretary.

Michigan State Medical Society, Grand Rapids, Sept. 27-29. Dr. L. Fernald Foster, 2020 Olds Tower, Lansing 8, Secretary.

Mississippi Valley Medical Society, Peoria, Ill., Sept. 27-28. Dr. Harold Swanberg, 510 Maine St., Quincy, Ill., Secretary.

Oregon State Medical Society, Portland, Sept. 2-3. Dr. Thomas D. Robertson, St. Vincent's Hospital, Portland, Secretary.

Pennsylvania, Medical Society of the State of, Pittsburgh, Sept. 19-21. Dr. Walter F. Donaldson, 500 Penn Ave., Pittsburgh 22, Secretary.

Radiological Society of North America, Chicago, Sept. 24-29. Dr. Donald S. Childs, 607 Medical Arts Bldg., Syracuse, N. Y., Secretary.

Wisconsin, State Medical Society of, Milwaukee, Sept. 18-20. Mr. Charles H. Crownhart, 110 E. Main St., Madison 3, Secretary.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Medical Practice Acts: Statutory Restrictions on Advertising by Physicians Valid.—A law enacted in Maryland in 1943 (Acts, 1943, c. 600) prohibits physicians from advertising. However, the law permits a physician (1) to use a personal professional card not larger than 3½ by 2 inches, on which may be printed his name, title, address, specialty, telephone number and office hours, (2) to mail to bona fide patients a removal notice not larger than 5 by 7 inches containing the information permitted on a personal professional card and (3) to exhibit on the building in which his office is located not more than two signs on which may be placed his name and degree, the letters of which shall not exceed 3 inches square, and to exhibit such a sign on the door of his office. A physician violating the provisions of the law is subject to a fine of from $50 to $300 for each offense. The law also denominates a violation of its provisions unprofessional conduct, which, in turn, is one of the causes set out in the medical practice act for the revocation of a license to practice medicine.

Davis, a licensed physician and who prior to the enactment of the 1943 law customarily advertised his skill in the treatment of venereal diseases, brought suit against the state of Maryland and certain individuals constituting the State Board of Medical Examiners for a declaratory judgment that the 1943 statute was unconstitutional. Since he had ceased to advertise, he alleged, because of the prohibition of the statute his professional income had been cut in half. The statute was unconstitutional, he claimed, because (1) it was not a valid exercise of the police power of the state but deprived him of his property without due process of law and (2) it was arbitrary and discriminatory and deprived him of the equal protection of the laws guaranteed by the federal constitution. A demurrer was interposed by the defendants, based on the theory that a state is immune from suit by an individual. The trial court offered Davis an opportunity to amend his bill of complaint so as to eliminate the state of Maryland as a party and on his refusal to amend sustained the demurrer and dismissed the bill. Davis then appealed to the Court of Appeals of Maryland.

The appellate court first discussed the propriety of using the declaratory proceeding to test the constitutionality of a statute and held that it was proper under the circumstances present in this case. The court next discussed the question as to whether or not the immunity of a state from suit is modified by the enactment of legislation providing for declaratory judgments, holding that even in a declaratory judgment proceeding the state is immune from suit and that hence the action of the trial court was proper in dismissing the bill of complaint because the state was made a party defendant to the proceedings.

Even though, for this reason alone, affirmance of the decree adverse to Davis was required, the court undertook to discuss the constitutional questions raised by Davis. The right to carry on any lawful business, trade or calling, said the court, is subject to regulation by the legislature under the police power of the state whenever necessary to promote in some degree the public health, morals or welfare. The legislature in enacting the statute in question aimed to aid in maintaining the high standard of ethics of physicians. The state has the power to see that only persons with special training and skill shall undertake the difficult and responsible duties of dealing with the health and lives of the people. The state is vitally concerned in attracting young people of ability to the practice of medicine and also in making it possible for those who are engaged in practice to survive without facing unseemly com-

petition, thus leaving them free to improve their qualifications without the necessity of devoting a large part of their time and effort to ruthless competitive pursuit for patients. The Maryland legislature determined that physicians of mediocre ability are likely to make up for lack of genuine merit by knowledge of mass psychology and skill in appealing to the emotions and hopes of the uninformed and credulous. Under the traditional method of professional advancement as a result of recommendations of satisfied patients, the progress of a practitioner may be slow but it bears more relation to merit; whereas mediocre practitioners who advertise extensively can obtain new patients by clever publicity as fast as the discovery of their mediocrity causes the loss of patients. It is well established that the state may lawfully forbid any advertising by medical practitioners that solicits patronage for the advertisers. *Laughney* v. *Maybury,* 145 Wash. 146, 259 P. 17. The legislature continued the court, had the right to determine, and did determine, that the public interest would be injuriously affected by unseemly competition of physicians for patients without any restraint as to methods of advertising and that the regulation of advertising by physicians is necessary for the public health, morals and welfare.

Davis argued that he was not objecting to a law prohibiting deceptive advertising or schemes to take advantage of the public, or to advertisements offering professional superiority, guaranteed work or free examinations. He contended, however, that the restrictions imposed by the 1943 act are stricter than are necessary for the public health, morals or welfare. As illustrative of the type of advertising prohibited by the 1943 act but which advertising he contended should be permitted he exhibited one of his advertisements reading as follows:

> Do you suffer from gland troubles? . . . Call today and get my honest opinion of your condition. . . . Thousands are sick and ailing from neglect. . . . Call today and start yourself on the road to health. One visit may save you many years of worry. . . . Charges moderate. Terms for all.

Necessarily, answered the court, there are limits to the valid exercise of the police power of the state. Otherwise the state legislature would have unbounded power and the constitutional restrictions would be meaningless, since it would be enough to say that any piece of legislation was enacted for the purpose of conserving the health, morals or welfare of the people. If, therefore, a statute designed for the public health, morals or welfare has no real or substantial relation to those objects or is a manifest invasion of rights secured by the fundamental law, it is the duty of the court to adjudge accordingly and thereby give effect to the constitution. But the police power is broad in scope and the legislature is vested with large discretion to determine not only what is injurious to the health, morals or welfare of the public but also what measures are necessary or appropriate for the protection of those interests. The exercise of the police power may inconvenience individual citizens, increase their labor or decrease the value of their property. The courts will not interfere with the exercise of power except where the regulations are arbitrary, oppressive or unreasonable. The wisdom or expediency of the regulations is not subject to judicial review. Of course, the police power is subject to the limitations imposed by the state and federal constitutions on every power of government, and the legislature will not be allowed to invade the fundamental liberties of the citizen. But unless regulations are so utterly unreasonable and extravagant in their nature that the personal and property rights of the citizen are interfered with or destroyed unnecessarily and in a wholly arbitrary manner without due process of law, they do not extend beyond the power of the legislature to enact and they form no subject for interference by the court. Applying this test, we find that the statute under review is a valid exercise of the police power of the state.

Davis contended, lastly, that the 1943 act was an unconstitutional discrimination because the restrictions on advertising set forth in that act are limited to physicians and do not extend to other professional classes. The state, said the court, is not bound to deal alike with all these classes or to strike at all evils at the same time or in the same way. It can deal with the different professions according to the needs of the public in relation to each. The decree of the trial court dismissing the complaint was accordingly affirmed.—*Davis v. State, 37 A. (2d) 880 (Md., 1944).*

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINING BOARDS IN SPECIALTIES

Examinations of the Examining Boards in Specialties were published in THE JOURNAL, Aug. 19, page 1155.

BOARDS OF MEDICAL EXAMINERS

ALABAMA: Montgomery, Oct. 24-26. Sec., Dr. B. F. Austin, 519 Dexter Ave., Montgomery.

ALASKA: Juneau, September 5. Sec., Dr. W. M. Whitehead, Box 561, Juneau.

ARIZONA: * Phoenix, Oct. 3-4. Sec., Dr. J. H. Patterson, 826 Security Bldg., Phoenix.

DELAWARE: Dover, Oct. 10-12. Sec., Medical Council of Delaware, Dr. J. S. McDaniel, 229 S. State St., Dover.

DISTRICT OF COLUMBIA: * Washington, November. Sec., Commission on Licensure, Dr. G. C. Ruhland, 6150 E. Municipal Bldg., Washington.

IDAHO: Boise, Jan. 8-11. Dir., Bureau of Occupational Licenses, Mrs. Lela D. Painter, 355 State Capitol Bldg., Boise.

ILLINOIS: Chicago, Oct. 10-12. Supt. of Registration, Department of Registration and Education, Mr. Philip Harman, Springfield.

INDIANA: Indianapolis, Jan. 3-5. Exec. Sec., Board of Medical Registration and Examination, Miss Ruth V. Kirk, 301 State House, Indianapolis 4.

IOWA: * Iowa City, Sept. 25-27. Dir. Division of Licensure and Registration, Mr. H. W. Grefe, Capitol Bldg., Des Moines.

KANSAS: Nov. 2-3 Sec., Board of Medical Registration and Examination, Dr. J. F. Hassig, 905 N. Seventh St., Kansas City.

KENTUCKY: Louisville, Sept. 11-13. Sec., State Board of Health, Dr. Philip E. Blackerby, 620 S. Third St., Louisville.

LOUISIANA: Sept. 7-9. Sec., Dr. R. B. Harrison, 1507 Hibernia Bank Bldg., New Orleans.

MICHIGAN: * Detroit, Sept. 25-27. Sec., Board of Registration in Medicine, Dr. J. E. McIntyre, 100 W. Allegan St., Lansing 8.

MINNESOTA: * Minneapolis, Aug. 29-31. Sec., Dr. J. F. Du Bois, 230 Lowry Medical Arts Bldg., St. Paul.

MISSOURI: St. Louis, Sept. 18-20. Sec., State Board of Health, Dr. James Stewart, State Capitol Bldg., Jefferson City.

MONTANA: Helena, Oct. 2-4. Sec., Dr. O. G. Klein, First Nat'l. Bank Bldg., Helena.

NEBRASKA: * Omaha, Sept. 26-28. Dir., Bureau of Examining Boards, Mr. Oscar F. Humble, 1009 State Capitol Bldg., Lincoln.

NEW HAMPSHIRE: Concord, Sept. 14-15. Sec., Board of Registration in Medicine, Dr. D. G. Smith, 77 Main St., Nashua.

NEW MEXICO: * Santa Fe, Oct. 9-10. Sec., Dr. LeGrand Ward, 141 Palace Ave., Santa Fe.

NORTH CAROLINA: Raleigh, Sept. 11-12. Sec., Dr. W. D. James, Hamlet.

OHIO: *Examination.* Columbus, Sept. 26-29. *Endorsement.* Columbus, Oct. 3. Sec., Dr. H. M. Platter, 21 W. Broad St., Columbus.

OKLAHOMA: * Oklahoma City, Sept. 16. Sec., Dr. J. D. Osborn, Jr., Frederick.

SOUTH CAROLINA: Charleston, Sept. 11-13. Sec., Dr. N. B. Heyward, 1329 Blandena St., Columbia.

SOUTH DAKOTA: * Pierre, Jan. 16-17. Sec., Medical Licensure, State Board of Health, Dr. G. Cottam, Pierre.

TENNESSEE: * Memphis and Nashville, Sept. 20-22. Sec., Dr. H. W. Qualls, 130 Madison Ave., Memphis 3.

TEXAS: Dallas, Nov. 15-17 and Dec. 19-21. Sec., Dr. T. J. Crowe, 918-20 Texas Bank Bldg., Dallas 2.

UTAH: Salt Lake City, Sept. 13-15. Asst. Dir., Department of Registration, Miss Rena B. Loomis, 324 State Capitol Bldg., Salt Lake City.

VERMONT: Burlington, Sept. 12-14. Sec., Dr. F. J. Lawliss, Richford.

VIRGINIA: Richmond, Sept. 19-22. Sec., Dr. J. W. Preston, 30½ Franklin Rd., Roanoke.

WEST VIRGINIA: Charleston, Oct. 2-4. Commissioner, Public Health Council, Dr. John E. Offner, State Capitol, Charleston 5.

WISCONSIN: * *Endorsement.* Milwaukee, Sept. 18-19. Sec., Dr. C. A. Dawson, Tremont Bldg., River Falls.

* Basic Science Certificate required.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

DISTRICT OF COLUMBIA: Washington, October. Sec., Commission on Licensure, Dr. G. C. Ruhland, 6150 E. Municipal Bldg., Washington.

FLORIDA: Gainesville, Nov. 4. Final date for filing application is Oct. 20. Sec., Dr. J. F. Conn, John B. Stetson University, DeLand.

IOWA: Des Moines, Oct. 10. Dir., Division of Licensure and Registration, Mr. H. W. Grefe, Capitol Bldg., Des Moines.

MICHIGAN: Ann Arbor and Detroit, Oct. 13-14. Sec., Miss Eloise LeBeau, 101 N. Walnut St., Lansing.

NEBRASKA: Omaha, Oct. 3-4. Dir., Bureau of Examining Boards, Mr. Oscar F. Humble, 1009 State Capitol Bldg., Lincoln.

NEW MEXICO: Santa Fe, Feb. 12. Sec., Miss Marion M. Rhea, State Capitol, Santa Fe.

OREGON: Portland, Nov. 4. Sec., Mr. C. D. Byrne, University of Oregon, Eugene.

TENNESSEE: Memphis and Nashville, Sept. 25-26. Sec., Dr. O. W. Hyman, 874 University Ave., Memphis.

WISCONSIN: Madison, Sept. 23. Sec., Prof. R. N. Bauer, 152 W. Wisconsin Ave., Milwaukee 3.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1934 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted be'

American Journal of Ophthalmology, Cincinnati

27:467-588 (May) 1944

Leiomyoma of Iris: Case Report. W. T. Davis, E. Sheppard and W. J. Romejko.—p. 467.
Suppression Amblyopia. H. S. Sugar.—p. 469.
Extradural Diploic Epidermoids Producing Unilateral Exophthalmos. E. H. Thornhill and B. Anderson.—p. 477.
*Congenital Cataract and Other Anomalies Following German Measles in Mother. A. B. Reese.—p. 483.
Metabolism of Cornea: Studies on Oxygen Consumption of Corneas of Riboflavin and Vitamin A Deficient Rats. O. S. Lee Jr. and W. M. Hart.—p. 488.
*Use of Tyrothricin, Bacterial Extract, in Treatment of Marginal Ulcers of Cornea. S. Bloomfield.—p. 500.
Exophthalmic Ophthalmoplegia: Report of Case with Thyrotoxicosis of Unusually Long Duration. I. D. Fagin, R. W. Pagel and H. H. Sand.—p. 504.
Duties and Training of Orthoptic Technician. W. B. Lancaster.—p. 515.
Treatment of Asthenopia—Nonpathologic and Nonrefractive in Origin. R. H. Pino and Greta L. Hultin.—p. 520.

Congenital Cataract Following German Measles in Mother.—Reese directs attention to a report from Australia of an epidemic of German measles and the occurrence of congenital cataract and other anomalies in infants born to mothers who had German measles during gestation. He cites 3 cases observed in New York within the past few months. All 3 of Reese's patients had congenital cataracts and congenital heart lesions. All mothers contracted German measles within the first month of pregnancy, which was during a rather severe epidemic of German measles in the East. The following questions present themselves in connection with these anomalies: 1. Is the infection of the mother German measles? 2. Why hasn't the occurrence of congenital anomalies in the children so infected been noted before? 3. Are the congenital anomalies which are now appearing the result of a more virulent type of German measles or of an altered type, which may have gained access to this country through an increased traffic with Australia? 4. Has the cause and effect relationship between other infections of the mother in the first three months of pregnancy and congenital anomalies existed in the past but has not been recognized? 5. Can prophylactic measures be taken to prevent pregnant women from contracting German measles during the first three months of pregnancy? 6. Should abortion be induced in pregnant women who contract exanthems in the first three months of pregnancy?

Tyrothricin in Treatment of Marginal Ulcers of Cornea.—According to Bloomfield the most frequent type of marginal ulcer of the cornea is that associated with the more severe catarrhal conjunctivitis. In these cases the keratitic complication is considered an extension of the septic process in the conjunctiva. Treatment with the usual antiseptics, occasionally supplemented by cauterization of the corneal lesion, usually results in rapid healing of the ulcer. Another group of marginal corneal ulcers, which is common in old people, is not associated with conjunctival inflammation. These arise as marginal, subepithelial infiltrates which coalesce and break down to form superficial erosions crescentic with the limbus. Local ciliary injection is usually present. Such superficial ulcers usually heal readily when antiseptic applications or cauterization and pressure dressings are employed. At the author's hospital 4 patients with this type of corneal ulcer were recently treated with tyrothricin because the ulcer was refractory to the usual treatments. Tyrothricin, a stable mixture of gramicidin and tyrocidine, is prepared from cultures of Bacillus brevis, a saprophyte found in sewage and soil. The poor absorbability and highly potent bacteriostatic action render it a safe and effective antiseptic against gram positive organisms by topical administration or the irrigation of infected body cavities. Tyrothricin was used with gratifying results in 4 cases of corneal ulcer. The drug appears to be an effective therapeutic agent in this condition. It may be safely applied to the conjunctival sac in effective concentrations.

Am. J. Roentgenol. & Rad. Therapy, Springfield, Ill.

51:537-668 (May) 1944

Diagnosis of Bronchiectasis in Young Adults: Prebronchographic Roentgen Manifestations Observed Among Military Personnel. W. A. Evans Jr. and L. J. Galinsky.—p. 537.
Ornithotic Pneumonia. A. Melamed and J. M. Fine.—p. 548.
Primary Cancer of Lungs. K. L. Mitton and N. M. Hardisty.—p. 555.
Roentgen Visualization of Tumors of Cardia. M. G. Wasch and B. S. Epstein.—p. 564.
Partial Paralysis of Hemidiaphragm. H. Abeles and G. C. Leiner.—p. 572.
Roentgenologic Changes in Esophagus in Tuberculous Mediastinitis. L. E. Hawes.—p. 575.
Correlation of Roentgenologic and Gastroscopic Examinations from Standpoint of Gastroenterologist. R. J. F. Renshaw.—p. 585.
Common Congenital Anomalies of Bony Thorax. L. K. Sycamore.—p. 593.
Importance of Roentgen Examination in Diagnosis of Adenoma of Prostate. A. Pereira.—p. 600.
*Metastasis to Bone as First Symptom of Cancer of Gastrointestinal Tract: Report of 3 Cases. E. J. Bertin.—p. 614.
Neurofibromatosis of Bone. M. M. Friedman.—p. 623.
Gas in Fetal Circulatory System as Sign of Intrauterine Fetal Death. J. B. Roberts.—p. 631.
Dislocation of Hip Associated with Spina Bifida. L. Nathanson and A. Lewitan.—p. 635.
Werner's Syndrome. S. T. Herstone and J. Bower.—p. 639.

Bone Metastases as First Sign of Cancer of Gastrointestinal Tract.—Bertin points out that cases in which bone metastasis is the first sign are rare. Three persons sought relief from symptoms caused by bone involvement. None of these patients presented important symptoms referable to the gastrointestinal tract. In 1 case an earlier diagnosis might have been made if bleeding from the rectum which occurred at intervals over a period of five years had been carefully investigated. In 2 cases there was nothing in the history or examination to suggest the presence of a deep seated malignant disease. In 1 case the metastatic lesion of the rib was painless at the time the chest roentgenogram was made. The bone lesions in the other 2 cases were moderately painful and showed definite tumor formation. Cancer of the digestive tract was not suspected in any of the 3 cases. The probable location of the primary growth was suggested by the microscopic examination. Gastrointestinal x-ray studies were made only after the pathologic diagnosis of adenocarcinoma had been made, and in each case the primary growth was found in the gastrointestinal tract: once in the stomach and twice in the sigmoid colon. Many of these cases are missed because it is usually not practical to make a complete x-ray examination of the entire osseous system unless there is a suspicion or sign or symptom suggesting bone involvement. The 3 cases were discovered in a series of 186 cases of carcinoma of the gastrointestinal tract over a period of ten years.

Archives of Internal Medicine, Chicago

73:365-432 (May) 1944

Bagasse Disease of Lungs. W. A. Sodeman and R. L. Pullen.—p. 365.
*Diffuse Isolated Myocarditis Associated with Dietary Deficiency. W. E. Toreson.—p. 375.
*Fatal Spontaneous Potassium Intoxication in Patients with Uremia. J. F. Marchand and C. A. Finch.—p. 384.
Vitamins A, B and C in Diabetic Children. H. O. Mosenthal and W. C. Loughlin.—p. 391.
Experimental Hypoproteinemia and Edema: Studies of Intestinal Absorption and Intestinal Roentgenologic Characteristics. A. J. Beams, A. H. Free and J. R. Leonards.—p. 397.
Bronchospasm Associated with Pulmonary Embolism: Respiratory Failure. N. H. Boyer and J. J. Curry.—p. 403.
Urinary Excretion of Nicotinic Acid and Its Derivatives. G. A. Goldsmith.—p. 410.
*Subacute Endocarditis Associated with Infection with A Spirillum. W. M. Hitzig and Ada Liebesman.—p. 415.
Salmonella Cholerae Suis Meningitis: Report of Case and Review of Literature on Salmonella Meningitis. E. R. Neter.—p. 425.

Myocarditis Associated with Dietary Deficiency.—The subject of Toreson's report was a girl aged 15 years with a history of prolonged malnutrition who died of a diffuse isolated myocarditis. Heart disease was known to have existed for at

least six months before death. Severe failure of the right side of the heart was progressive; left bundle branch lesion, heart block and ventricular fibrillation preceded death. The heart showed dilatation and hypertrophy with acute, subacute and chronic, noninfective inflammatory lesions diffusely distributed throughout the myocardium. The lesions were most extensive in the inner third of the myocardium, and in places they encroached on the endocardium. Mural thrombi were found in both auricles and in both ventricles. The possibility that the myocardial lesions may have been incited by prolonged dietary deficiency is suggested by the history of prolonged malnutrition. Deficiency of thiamine is particularly suspected.

Fatal Spontaneous Potassium Intoxication in Uremia.—Marchand and Finch report 2 cases in which potassium intoxication resulted from oliguria and failure of renal excretion. No potassium was given other than that contained in the diet and in the blood which was transfused into the first patient. The second patient did not have a blood transfusion and took no food during the week before death. The failure in excretion of potassium resulted in an increase in the concentration of potassium in the serum to 9.8 and 10.1 milliequivalents, while the concentration in the pericardial fluid was 9 and 8.8 milliequivalents and that in the spinal fluid 4.5 milliequivalents per liter at death. Serial electrocardiograms showed the characteristic changes leading to cardiac arrest by the action of potassium, including evidence of auricular arrest and progressive delay of conduction in the ventricles. The symptoms were those of uremia. Consciousness persisted up to the time of death in the first case but became clouded in the second case. In the first case the intravenous injection of a solution of calcium gluconate resulted in transient restoration of regular rhythm. The cessation of respiration in each case was preceded by circulatory failure, and there was evidence that the heart was arrested in diastole. In each of these cases the development of a high concentration of potassium in the serum was associated with failure of renal excretion sufficient to produce other evidence of azotemia. There was no indication of any toxic effect from potassium until after the interval of oliguria, and it is evident that there was no significant failure in excretion of potassium until after failure of water excretion had begun. The three sources from which the high concentration of potassium in the serum appears to have been derived were diet, red cells introduced by transfusion of blood and tissue metabolism. Of these the last in itself has regularly sufficed to cause death of animals with experimental anuria. In the second case the elevated level of potassium appears to have been derived largely from tissue metabolism, since no transfusion was given and no food was taken in the last week of life.

Subacute Endocarditis Associated with Spirillum Infection.—Hitzig and Liebesman observed an unusual case of subacute endocarditis in which the causative micro-organism was Spirillum minus. This organism was isolated six times from the blood in dextrose and tomato bouillon and grown in an atmosphere of 3.5 per cent carbon dioxide. Its relation to the causative organism of rat bite fever was established by its morphologic characteristics, its pathogenicity and serologic effects in man and its invasiveness for mice. Despite the unusual micro-organism, the clinical course and the changes observed at necropsy were strikingly similar to those observed in cases of the common form of subacute bacterial endocarditis due to Streptococcus viridans. The classic features observed in this case were low grade fever with occasional increases in temperature, endocardial murmurs, splenomegaly, multiple visceral and subcutaneous embolization, microscopic hematuria, petechiae, Osler and Janeway lesions and subarachnoid hemorrhage as terminal event. That the endocarditis was subacute was clearly established by its long duration, i. e. an interval of nineteen weeks from the earliest febrile episode to the termination of the illness. The isolation of Spirillum minus from the blood culture led to speculation as to the cause and pathogenesis of the endocarditis. At first there was doubt as to the etiologic role of the micro-organism identified as Spirillum minus, since there was no history of rat bite. On closer investigation it was found that the food ingested by the patient at the water front was exposed to rats and wild cats. The patient also had direct contact with alley cats, a fact which might be significant, since a case of rat bite fever following a cat bite has been reported.

Archives of Surgery, Chicago

48:355-422 (May) 1944

Permeability of Lymph Vessels and Lymph Pressure. F. C. Lee.—p. 355.
Administration of Succinylsulfathiazole Before and After Hemorroidectomy. L. L. Leveridge.—p. 366.
*Traumatic Retroperitoneal Rupture of Duodenum: Presentation of Case and Review of Literature. M. L. Johnson.—p. 372.
Oral Administration of Diethylstilbestrol for Prostatism: Clinical Evaluation. W. Klein and B. Newman.—p. 381.
Prosthetic Restoration for Breast: Technic Using Sponge Rubber. A. M. Brown.—p. 388.
*Intravenous Administration of Fat for Nutritional Purposes: Experimental Study. L. J. Dunham and A. Brunschwig.—p. 395.
Osgood-Schlatter Disease. E. Uhry Jr.—p. 406.
Interstitial Cell Tumors of the Testis: Report of 3 New Cases. E. F. Nation, H. A. Edmonson and R. W. Hammack.—p. 415.

Retroperitoneal Rupture of Duodenum.—Johnson reports the case of a boy aged 10, who was hospitalized twenty hours after having been struck by an automobile. The right side of his abdomen and back became progressively more tender, and he vomited whenever he attempted to take water; there was no blood in the vomitus. He had a normal bowel movement the following morning and normal urination. The abdomen was slightly distended and was more rigid on the right side. The points of greatest tenderness were the right costovertebral angle, the flank and the upper right quadrant of the abdomen. There was clear transmission of the cardiac sounds over the entire right side of the abdomen (Claybrook's sign). A few borborygmi were heard. There was a small area of ecchymosis slightly to the left of the umbilicus. A roentgenogram with the patient in the upright position showed no evidence of air in the peritoneal cavity, and the intestines were normal. Laparotomy was performed. The large and small bowel, stomach and urinary bladder were examined before a small area of edema and yellowish discoloration of the parietal peritoneum just lateral to the flexion of the duodenum was investigated. The visceral peritoneum was incised and explored, the lesion being easily found on the lower later curve of the posterior part of the duodenum. Mobilization of the duodenum was essential to identification and closure of the rupture. Drainage lasted several weeks. The author found 52 cases of retroperitoneal rupture of the duodenum by blunt trauma recorded in the literature between 1916 and 1943. In 7 of these the lesion was not found at the operation. Cure was obtained in 26 cases. Whenever edema, bile staining, hematoma or emphysema occur over the retroperitoneal area of the duodenum, the surgeon must explore. The rupture must be closed, but a short circuiting operation should be done only if the closure of the rupture produces obstruction. Proper drainage of the peritoneal cavity and the retroperitoneal space is essential. The stomach or duodenal tube must be used to put the traumatized area at rest. Sulfonamide drugs should be employed intelligently. Complications may arise following the treatment, the most serious of which are peritonitis, retroperitoneal cellulitis and duodenal fistula.

Intravenous Administration of Fat for Nutritional Purposes.—Dunham and Brunschwig found that dogs on a diet of commercial dog food of low fat content exhibited changes in the characteristics (iodine and saponification numbers) of the depot fat. Dogs receiving the same diet plus intravenous infusions of emulsified fat of appreciably different quality from dog fat did not exhibit sufficient differences from the control group in alteration of the iodine and saponification numbers to indicate appreciable physiologic storage of such infused fat. Changes in melting points of the depot fats in some of the animals given infusions, however, did suggest some storage of infused fat. Protein sparing effects were not demonstrable by intravenous injection of highly emulsified fat (except in 1 of 5 dogs), but such effects did result when comparable amounts of an emulsion were administered by mouth. This further indicated lack, or extreme limitation, of utilization of intravenously administered fat. Microscopic examination of tissues taken after infusions

of fat showed increased fat in the liver, in macrophages in the spleen, in tubular epithelium of the kidneys and scattered sparsely in capillaries and macrophages in the lungs. After administration of coarser or less stable emulsions there were large fat globules in sinuses in the liver, often in the Kupffer cells and in sinuses in the spleen, increased fat in the renal tubules and glomeruli and pulmonary capillaries loaded with fat. The foreign fat diminished with the passage of time. There was an increased amount of hemosiderin in macrophages mobilized in the regions of accumulation of foreign fat, especially in the spleen. The fat infusions produced severe secondary anemia, which disappeared after the infusions were discontinued. The infusions of fat were probably responsible for the deaths of 9 of 24 dogs; hence such infusions are not without danger. The surviving dogs appeared to maintain good health.

Canadian Medical Association Journal, Montreal

50:505-600 (June) 1944

Certain Nutritional Aspects of High Extraction Wheaten Flours. T. Moran.—p. 505.
Job Misfits—Work Conditions. D. E. Cameron.—p. 508.
Arthralgia. T. G. Heaton.—p. 515.
Investigation of Pneumothorax and Respiratory Function at Altitude. E. W. Peterson, B. S. Kent, H. R. Ripley and D. R. Murphy.—p. 520.
Intestinal Gas Volumes at Altitude. E. W. Peterson, B. S. Kent and H. R. Ripley.—p. 523.
Diverticula of Stomach. D. Telford.—p. 526.
Primary Carcinoma of Liver Combined with Tuberculosis and Diabetes Mellitus. G. H. C. Joynt.—p. 529.
*Resistance to Treatment in Early Syphilis. F. Kalz.—p. 534.
Discussion of Some Common Conditions, Generally Unrecognized or Untreated, Based on Thirty Years' Clinical Experience. W. A. Bigelow.—p. 536.
Fungous Infection of Mouth and Throat and Nose and Ear. A. L. Yates.—p. 540.
The Chinese Doctor and War. R. B. McClure.—p. 543.
Test for Increased Coagulability of Blood. T. R. Waugh and D. W. Ruddick.—p. 547.
Standardization of Blood Hemoglobin Determinations. H. B. Collier.—p. 550.
Effect of Mercury Indigo Disulfonate on Liver Cancer of Rats. J. E. Davis.—p. 553.

Resistance to Treatment in Early Syphilis.—Kalz stresses that resistance to therapy in syphilis is a serious problem for physician and patient and a menace from the public health point of view. He reports 3 such cases. Case 1 displayed an ocular relapse occurring after insufficient treatment and "cure" after intensified arsphenamine therapy. In case 2 a periostitis and precocious tertiary skin lesions developed while weekly injections of mapharsen 0.06 Gm. were being given but responded well to intensive therapy with arsphenamine. In case 3 resistance to neoarsphenamine 0.75 Gm., given once a week, was observed and mucous patches and papular secondaries with spirochetes and periostitis developed. An interesting feature was the persistent seronegativity. Symptomatic cure was achieved with mapharsen 0.06 Gm. twice a week. In all 3 cases therapy previously considered as adequate failed to arrest progression of the syphilitic infection, while intensified arsenical therapy brought about clinical and serologic cure. The author observed numerous patients in whom mapharsen, given once a week, failed to reverse the positive blood tests, while more intensive therapy with either mapharsen or arsphenamine brought about serologic reversal in a short time. If general improvement, serologically or otherwise, does not occur with intensified therapy and change of drug, such measures as injection of foreign protein, ultraviolet ray therapy and high vitamin intake may prove of value. If not, fever therapy in conjunction with arsenotherapy may be tried. The author has not observed resistance to treatment in primary or secondary syphilis when 0.06 Gm. of mapharsen was given twice a week. Mapharsen given once a week in a dose of 0.06 Gm. is insufficient for the treatment of early syphilis.

Delaware State Medical Journal, Wilmington

16:51-58 (April) 1944

New Method of Skin Grafting. M. E. Sano.—p. 51.

16:59-72 (May) 1944

Operative Treatment of Cancer of Large Bowel. W. W. Babcock.—p. 59.
Gynecomastia. C. W. Dunn.—p. 63.

Endocrinology, Springfield, Ill.

34:301-352 (May) 1944

Augmentation of Castrate Urinary Gonadotropin by Nonspecific Urinary Component. Beatrix G. Smith.—p. 301.
Effects of Adrenocorticotropic Hormone on Osseous System in Normal Rats. H. Becks, Miriam E. Simpson, C. H. Li and H. M. Evans.—p. 305.
Antagonism of Pituitary Adrenocorticotropic Hormone to Action of Growth Hormone on Osseous System of Hypophysectomized Rats. H. Becks, Miriam E. Simpson, W. Marx, C. H. Li and H. M. Evans.—p. 311.
Anatomic Effects of Thiouracil. R. H. Williams, A. R. Weinglass, G. W. Bissell and J. B. Peters.—p. 317.
Thymus Weight in Relation to Body Weight in Castrated and in Adrenalectomized Rats. H. C. Stoerk.—p. 329.
Intrasplenic Injection of Some Synthetic Estrogens and Proestrogens. A. Segaloff.—p. 335.
Influence of Sex Hormones on Bursa of Fabricius and Pelvis in Ring Necked Pheasant. C. M. Kirkpatrick and F. N. Andrews.—p. 340.
Role of Vitamins of B Complex in Estrogen Metabolism. A. Segaloff and Ann Segaloff.—p. 346.

Indiana State Medical Assn. Journal, Indianapolis

37:279-340 (June) 1944

Present Day Employment of Physically Handicapped Under Federal Civil Service. V. K. Harvey.—p. 279.
Putting Veteran Back to Work. W. A. Smith.—p. 282.
Training of Industrial Physicians. J. T. Oliphant.—p. 283.
*Practical Program for Human Rehabilitation. H. A. Vonachen.—p. 289.
Obligations of University in Training Industrial Physicians. W. D. Gatch.—p. 292.
Disability Evaluation. E. D. McBride.—p. 293.
Value of Industrial Medical Service in Industry. V. G. Heiser.—p. 295.
Preventive Medicine in Industry. J. H. Foulger.—p. 297.
Fungus Allergy and Industrial Dermatitis. S. M. Peck.—p. 304.
Postwar Industrial Health Problems. R. L. Sensenich.—p. 307.

Program for Rehabilitation.—Vonachen, medical director of the Caterpillar Tractor Company of Peoria, Ill., points out that this company realized about eighteen months ago that some of its thousands of employees now in service would return with physical handicaps. A survey was made in which each supervisor listed the jobs in his department which could be performed by employees with the handicaps listed on survey cards. With this information the personnel division, with its knowledge of "job analysis," was ready to interview the individuals and then present the applicant to the medical division for its approval of the specific job chosen. A personal interview followed, impressing on the employee the necessity for care and safety in his work. Many of the employees with physical handicaps are attending special classes given by a training school in order that they may advance in their quest of independence. This program has been successful, for the vast majority of these people have a production, safety and absentee record above normal. They are paid the same rate as normal persons; they are shown no special favors and are in no way considered as accepting charity. In Caterpillar's handicapped group are only those with the loss of one or both extremities, pronounced deformities, loss of one or both eyes, loss of hearing and speech, and those with healed tuberculosis, heart disease and the like. At present Caterpillar has approximately 800 such handicapped employees, and this number is remarkable when consideration is given to the fact that it builds heavy machinery. After Caterpillar assured itself of the success of this program in its plant, it felt that the plan should be carried forward to the community. The idea was offered to the Peoria Manufacturing Association, and from this came "The Peoria Plan for Human Rehabilitation—Civilian and Military," which the author believes is the first to be established in a community with a complete working organization.

Journal of Industrial Hygiene & Toxicology, Baltimore

26:183-210 (June) 1944

Physiologic Aspects of Traumatic Shock. J. C. Aub.—p. 183.
Management of Hand Injuries. H. Marble.—p. 189.
Determination of Concentration of Monoalkyl Ethylene Glycol Ethers in Air by Infra-Red Absorption Spectroscopy. C. Z. Nawrocki, F. S. Brackett and H. W. Werner.—p. 193.
Sensitive, Portable, Self-Contained Phototube Colorimeter for Field Determination of Cyanide in Air. D. Lester and P. F. Ordung.—p. 197.
Survey of Medical and Sanitary Facilities in Small Industrial Establishments. Beatrice Kresky and T. Rosenthal.—p. 201.
Control of Silica Dust Hazard in Quartz Crystal Cutting and Grinding. A. E. Goss.—p. 208.

Public Health Reports, Washington, D. C.

59:701-732 (June 2) 1944

Strain of Typhus Rickettsiae Isolated from Brain of Wild Rat in California. M. Dorothy Beck, H. L. Bodily and Rosemary O'Donnell. —p. 701.
Prevalence of Poliomyelitis in United States in 1943. C. C. Dauer. —p. 712.

59:733-764 (June 9) 1944

Sulfarsphenamine in Therapy of Syphilis: A Comparative Study of Toxic Manifestations of Neoarsphenamine and Sulfarsphenamine. T. F. Probey, E. W. Norris, A. V. Deibert and Eleanor V. Price. —p. 733.

Radiology, Syracuse, N. Y.

42:425-530 (May) 1944

Roentgen Diagnosis of Primary Atypical Pneumonia. E. K. Lewis and F. B. Lusk.—p. 425.
*Comparative Roentgen Study of Primary Atypical and Bacterial Pneumonia. G. H. Stein and P. J. Kresky.—p. 435.
*Roentgen Study of Primary Atypical Virus Pneumonia. G. Levene and Ida A. Sterman.—p. 446.
Tomography in Region of Maxillary Sinuses. E. H. Holvey and L. M. Rosenthal.—p. 458.
Some Roentgen Aspects of Pancreatic Necrosis. G. J. Baylin and K. D. Weeks.—p. 466.
Reciprocity Law Failure in X-Ray Films. R. H. Morgan.—p. 471.
Supervoltage Roentgen Therapy of Esophageal Carcinoma. F. Buschke and S. T. Cantril.—p. 480.
Place of National Cancer Institute in Cancer Program. R. R. Spencer. —p. 493.

Roentgen Study of Primary Atypical and Bacterial Pneumonia.—Stein and Kresky state that during the twelve months from August 1942 through July 1943 2,062 cases of pneumonia were seen at the Regional Station Hospital in Sioux Falls, S. D.; 950 were bacterial pneumonias and 1,112 were primary atypical pneumonias. From a review of these cases they have come to the conclusion that any attempt to determine the probable etiology of a case of pneumonia from the roentgenogram alone is an extremely inaccurate procedure. Cases of primary atypical pneumonia may present an x-ray appearance indistinguishable from that of pneumococcic or other bacterial pneumonias, especially the early and/or resolving stages of the latter. Contrary to most descriptions in the literature, the authors have seen many cases of atypical pneumonia which did not originate in the hilar regions and extended outward but occurred as circumscribed foci in the periphery of the lung field. They have also seen primary atypical pneumonias occurring in the upper lobes with x-ray findings simulating those of tuberculosis, as mentioned by Moore and his associates. They present 19 cases which demonstrate the variations of x-ray shadows in both bacterial and primary atypical pneumonia. Any attempt to establish an etiologic diagnosis from the x-ray findings alone, without a knowledge of the clinical symptomatology, laboratory findings and clinical course, is certain to result in inaccurate diagnoses.

Roentgen Study of Primary Atypical Virus Pneumonia.—Levene and Sterman report studies in 100 consecutive cases of virus pneumonia observed in the Department of Radiology of the Massachusetts Memorial Hospitals. From a roentgenologic standpoint virus pneumonia appears to be a disease of the tracheobronchial system with secondary changes in the lungs. It produces fairly characteristic pulmonary changes. These consist of tracheobronchitis, peribronchitis, focal atelectasis, edema and emphysema. The presence of emphysema militates against total lobar atelectasis, so that uniform consolidation is infrequently observed. Roentgenograms show clearing of the lungs on the seventeenth day and a return to normal on the twenty-fifth day. Resolution progresses centripetally, the peripheral portions of the lungs being the first to clear. Roentgenologic evidence of interstitial pneumonitis and partial atelectasis may remain long after clinical cure. Since this may suggest the possibility of the development of chronic complications, particularly of bronchiectasis, it would appear to be good practice to take a roentgenogram of the chest on the day of discharge and another, where indicated, at a short interval thereafter.

South Carolina Medical Assn. Journal, Florence

40:91-108 (May) 1944

Management of Thyrotoxicosis, by Classical Iodinization Method and by Use of Thiouracil. T. P. Sprunt.—p. 91.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Radiology, London

17:133-164 (May) 1944

Indications for and Effects of Irradiation of Pituitary Gland: Symposium. E. A. Kahn, A. C. Crooke and J. F. Bromley.—p. 133.
Value of Opaque Enema and Its Modifications. N. P. Henderson. —p. 140.
Fine Control for Kilovoltage of High Tension Generator. F. S. Stewart.—p. 149.
Energy Absorption: II. Part I. Integral Dose When Whole Body is Irradiated. W. V. Mayneord and J. R. Clarkson.—p. 151.
Four Inch Packing Nail in Lung: Case Followed for Thirteen Years. J. B. Hartley.—p. 157.
New Integrating Dosemeter for X-Ray Therapy. F. T. Farmer. —p. 160.
Calcification in Guinea Worm. J. A. Brocklebank.—p. 163.

British Medical Journal, London

1:547-580 (April 22) 1944

*Etiology of Postarsphenamine Jaundice. J. Beattie and J. Marshall. —p. 547.
What Is Psychiatry? A. Gregg.—p. 550.
Ocular Syndrome in Onchocerciasis. J. G. Scott.—p. 553.
*Nervous Complications of Infective Hepatitis. F. G. Lescher.—p. 554.
Surgical Problems in Forward Areas. G. Blackburn.—p. 556.

1:581-610 (April 29) 1944

Wartime Incidence of and Mortality from Respiratory Tuberculosis. P. Stocks and E. Lewis-Faning.—p. 581.
Relation of Dermatology to Psychiatry. F. F. Hellier.—p. 583.
Sickness Records of Nurses in General Hospital. Joyce Wright.—p. 585.
Cyclopropane for Dental Surgery in Children. K. B. Pinson.—p. 588.
Early Secondary Repair of Complete Tears. P. Malpas.—p. 590.

Etiology of Postarsphenamine Jaundice.—Beattie and Marshall point out that apparently two types of hepatitis occur during arsenic therapy: (1) an early type, which is usually mild and appears within the first two weeks after the first injection of the drug, and (2) a late type, which may appear at a variable time after starting treatment but usually becomes obvious between the twelfth and seventeenth weeks of treatment. They are concerned with the late type, which at their clinic increased from 2 per hundred cases of early syphilis under arsenic treatment to 46 per hundred cases. Observations indicated that although syphilis and the arsenicals can produce liver damage they cannot be responsible alone for the increase in jaundice. Ruge had made the observation that in the German navy the incidence of jaundice in the syphilitic bore a relation to the incidence of infective (nonspirochetal) jaundice in the general population. The present rapid rise in the incidence of jaundice among the syphilitic in Britain also has been observed over a period when infective hepatitis was becoming increasingly common in the general population. The authors investigated the possible role of infection in 119 cases of postarsphenamine jaundice in which all the antisyphilitic treatment was administered at one clinic. The length of the incubation period and the possibility that an infective agent had been transmitted by inoculation suggested that postarsphenamine jaundice might be identical with the jaundice which occurs after the administration of human blood products or of yellow fever vaccine containing human serum. It was suggested by MacCallum early in 1943 that if transmission of the infective factor in postarsphenamine jaundice was due to inoculation of infective material contained in imperfectly sterilized syringes, then if each patient was given a syringe at the beginning of his treatment and received injections only by that syringe the transmission of infection ought to be eliminated. It was decided to give each of 10 patients with early syphilis a new and unused syringe for his exclusive use for all his injections. Such syringes and needles were washed and boiled both before and after each injection. Because of posting to units away from the command only 4 of the 10 were observed beyond one hundred and twenty days after the first treatment. No case of jaundice appeared in this group in spite of the fact that the patients were in contact for about the first fourteen days of treatment, and subsequently at least once each week, with men who later developed postarsphenamine jaundice. The authors present considerations which suggest that there is an X disease which has an incubation period of about twenty-eight to thirty days and is transmitted by contact

and a Y disease, which has an incubation period of eighty to one hundred days and is transmitted by inoculation of infective material (blood, serum or plasma). An attack of Y disease presumably confers no immunity against X disease. Evidence that an attack of X disease confers no immunity against Y disease is scanty and incomplete but is suggestive. Relapses of Y disease have been explained mostly on the grounds of an infection with X disease.

Nervous Complications of Infective Hepatitis.—According to Lescher, nervous symptoms occur occasionally during spirochetosis icterohemorrhagica and also, but even more rarely, during infective hepatitis. Meningitis is the nervous complication most commonly encountered in both diseases. Disease of the nervous parenchyma, though it does occur, is rare in both infections. The authors describe meningitis in a patient with spirochetosis icterohemorrhagica and also in 2 patients with epidemic hepatitis. In 1 of these 2 polyneuritis developed, and in the other hemiplegia, presumably due to an encephalitis, occurred within a few weeks of the attack of epidemic hepatitis. While the possibility of coincidence has been kept in mind, the probability is that the hepatitis and the nervous complications are but two phases of the same disease. This combination may be found to be not quite so uncommon as was formerly supposed, especially if the presence of latent jaundice is looked for in all cases of infective nervous disease of doubtful etiology.

1:611-642 (May 6) 1944

Control of Dust Borne Streptococcal Infection in Measles Wards. Joyce Wright, R. Cruickshank and W. Gunn.—p. 611.
*New Technic for Application of Dust-Laying Oils to Hospital Bedclothes. F. C. Harwood, J. Powney and C. W. Edwards.—p. 615.
*Oiled Floors to Control Respiratory Infection: Army Experiment. P. H. R. Anderson, J. A. Buchanan and J. J. MacPartland.—p. 616.
Determination of Basal Metabolism on Outpatients. J. D. Robertson.—p. 617.
Nutritional Edema in a Vegetarian. J. MacD. Holmes.—p. 620.
Aerial Convection from Smallpox Hospitals. C. K. Millard.—p. 628.

Application of Dust-Laying Oils to Hospital Bedclothes.—According to Harwood and his associates the treatment of bedclothes with dust-laying oils for the purpose of reducing dustborne infection in hospital wards has been investigated. The application of from 3 to 7 per cent of liquid petrolatum or of technical white oil to bedclothes caused a large reduction of dustborne bacteria in the air of hospital wards. Two distinct methods of applying the oil to bedclothes were studied: (*a*) impregnation with oil dissolved in a volatile organic solvent, (*b*) impregnation with concentrated oil-in-water emulsions. Neither of these processes permits accurate control of quantities, while both methods entail a recovery process for the unused oil and would present considerable difficulty in large scale operation in a hospital laundry. The National Institute for Medical Research invited the cooperation of the British Launderers' Research Association with regard to this difficulty, and an investigation was carried out in which the use of dilute aqueous emulsions for oiling was considered in detail. As a result of this work an efficient and economic process has been evolved. It has been found possible by the use of suitable emulsifiers to oil hospital bedclothes to any required degree by means of very dilute oil-in-water emulsions. The particular advantage of the present process is that complete exhaustion of the emulsion takes place, and there is therefore no necessity for applying an oil recovery process to the used liquor. Both positively charged and negatively charged oil emulsions have been employed, either separately or in equivalent amounts. The cation active emulsifier "fixanol C" and the anion active emulsifier "teepol" have been used in the present investigation, but there is no reason why other commercial emulsifiers of similar types should not be used. The methods described are applicable on a large scale in any hospital laundry that observes a correct washing technic.

Oiled Floors to Control Respiratory Infection.—Anderson and his associates investigated the oiling of floors to see if it could be used to cut down the spread of air borne infections among soldiers in barracks. The experiment involved men in two army units, A and B, each of which was a large training center occupying one complete barracks. Oiling of floors was carried out in unit A, while in unit B, which served as a control, the floors were untreated. The two barracks were almost identical in structure, and the men in the two lived and worked under closely comparable conditions. In unit A the wooden floors of all barrack rooms, sleeping huts, offices and lecture rooms were treated with spindle oil at regular intervals. The oil was applied in such a way as to leave an imperceptible film on the surface after thorough impregnation of the wood. Oil treatment of the floors of unit A began in November 1942. The oil was noninflammable and caused no unpleasant smell. The surface dried in about six hours. One gallon of oil was enough to treat about 1,000 square feet of floor space. Second and subsequent applications were made at intervals of about four weeks. After treatment the floor was not scrubbed but was easily kept clean by brushing or occasional moppings with a rag moistened in oil. The floors of unit B—the control unit—were left untreated, and in both units careful weekly records were kept of all men reporting sick with a respiratory infection during the seventeen weeks ended March 27, 1943. In the unit where floors were oiled the average rate of respiratory infections was 7 per thousand men, as against 38 per thousand men in the control unit. No major outbreak of respiratory infection appeared in the test unit; in the control unit an outbreak of almost epidemic proportions prevailed between the middle of February and the first week of March.

Journal of Royal Army Medical Corps, London

82:151-202 (April) 1944

Medical Aspects of Occupation of Captured Enemy Towns and Ports. W. L. Spencer-Cox.—p. 151.
Camp Siting in Malarious Districts of West Africa. C. R. Ribbands.—p. 157.
Some Experiences with a Parachute Surgical Unit. C. G. Rob.—p. 165.
Divisional Field Ambulance in Mobile Warfare. R. Johnston.—p. 168.
Importance of Failure of Concentration in Acute War Neurosis Syndrome. R. F. Tredgold.—p. 177.

Lancet, London

1:555-586 (April 29) 1944

Forward Surgery of Abdominal Wounds. W. H. Ogilvie.—p. 555.
Chronic Sinusitis with Polypi: Radical External Operation. N. Patterson.—p. 558.
Chronic Sinusitis with Polypi: Results of Patterson's Operation. S. W. G. Hargrove.—p. 560.
Regional Anesthesia for Surgery of Nose and Sinuses. H. W. Loftus Dale.—p. 562.
Treatment of Arthritis with Acid Potassium Phosphate. H. W. Crowe.—p. 563.
Vaccines and Chemotherapy in Pneumococcal Lobar Pneumonia. A. Dick.—p. 564.
Nicotinic Acid and Riboflavin in Beef Extracts and Corned Beef. R. G. Booth and E. C. Barton-Wright.—p. 565.

Revista Chilena de Pediatría, Santiago

15:169-248 (March) 1944. Partial Index

Early Cutaneous Tuberculosis in Children. A. Dabancens L.—p. 203.
*Neurologic Syndromes Due to Tuberculosis of Nervous System. R. Matte L. and R. Galecio G.—p. 213.
Food Allergy in Infants: Means for Diagnosis. W. Bustamante E.—p. 240.

Neurologic Syndromes Due to Tuberculosis of Nervous System.—Matte L. and Galecio G. report 5 cases of tuberculosis of the nervous system complicating primary pulmonary tuberculosis in infants and young children. Neurologic symptoms were present in 4 cases. The first patient exhibited symptoms of a cerebral tumor. The second and third patients presented hemiplegia as the first symptom of terminal tuberculous meningitis of ten and five days' duration respectively. The fourth patient complained of acute supraorbital neuralgia for the last four months in the course of primary pulmonary tuberculosis of nine months' duration. Necropsies showed primary pulmonary tuberculosis with cavitation and hematogenic spread of tuberculosis in all of the cases. A large cerebellar tuberculoma was found in the first case. A large cerebral tuberculoma was present in the second and third cases. Multiple cerebral tuberculomas were encountered in the fourth case. Neurologic symptoms of definite value for the diagnosis of cerebral tuberculoma did not appear in the last three cases in which tuberculoma was a necropsy finding. The cause of death in the cases reported was tuberculous leptomeningitis.

Book Notices

The Evolution of Tuberculosis as Observed During Twenty Years at Lymanhurst, Minneapolis Board of Public Welfare, 1921 to 1941. Price, $2.50. Paper. Pp. 253, with illustrations. Minnesota Public Health Association. St. Paul, 1944.

This volume is the result of twenty years of observation and study of tuberculosis among children and young adults who as far as possible were observed to determine how the disease evolves in the bodies of persons who are infected in infancy, childhood and early adult life.

The tuberculin test, the author believes, affords the best criterion of the accomplishments in tuberculosis control over a period of years as well as the present situation.

During the first ten years stereoscopic x-ray films were made of the chests of all children, regardless of the tuberculin reaction. Never was any evidence of clinical tuberculosis found in the lungs of nonreactors. Therefore, x-ray inspection of the chest was discontinued. Moreover, single films were substituted for stereoscopic films. In 1934, after adequate trial, x-ray film on paper base was as satisfactory as on celluloid base, and therefore the paper x-ray film of the standard size was subsequently employed. It was concluded that no x-ray film, regardless of base or size, is adequate for final diagnosis. X-ray film inspection of the chest is indispensable in detecting the presence of disease which has attained macroscopic proportions, but microscopic etiology can never be determined with accuracy from the shadows of macroscopic lesions alone.

Among those who had primary tuberculosis as manifested by the tuberculin reaction, the x-ray film revealed evidence of such lesions in only about 30 per cent. The x-rays cannot be considered a substitute for the tuberculin test, but neither is the tuberculin test a substitute for the x-rays. In observing the chests of the same individuals over a period of years, it was found that the location of the lesions in those who develop chronic clinical pulmonary tuberculosis can often be determined by x-ray inspection two or three years before they cause significant symptoms or become contagious and usually before other phases of the physical examination are of any avail. Despite these findings, the physicians did not abandon palpation, percussion and auscultation, which often bring to light evidence of disease in certain areas of the lungs and in other parts of the body which do not lend themselves well to x-ray inspection.

After thirteen years of observation and study, it was decided that treatment of children with the first infection type of tuberculosis is of little avail, either immediately or remotely, and therefore it was recommended that the treatment division of the Lymanhurst School be abandoned and that the funds be diverted to more effective tuberculosis work; namely, testing as many children as possible with tuberculin, the reactors to be examined periodically after attaining adulthood, and examining their adult associates for contagious tuberculosis and breaking the contact as soon as possible. This necessitated a clinic for adults where such contacts could be examined, which was established in 1935.

Observations proved that the first infection type of tuberculosis is an extremely benign disease. Over the twenty year period no child was found to be significantly ill from this form of tuberculosis. However, it prepared the way for reinfection clinical forms of disease by causing sensitivity of the tissues to tuberculoprotein and often by providing tubercle bacilli for reinfections. Acute forms of the disease, such as meningitis, miliary disease and pneumonia, are reinfection types of tuberculosis. Nearly always when an opportunity exists one can detect the presence of primary tuberculosis before these highly destructive reinfection forms appear.

The belief that children under 5 years of age tolerate infection with tubercle bacilli poorly was not substantiated. In a group of 813 children who were found to be reactors to tuberculin between birth and the age of 5 years 11 (1.35 per cent) died of meningitis, miliary tuberculosis or tuberculous pneumonia. Eleven others as children developed extrathoracic clinical tuberculosis, of whom none died. There were 9 who later developed chronic pulmonary tuberculosis. The average age at which this occurred was 14.5 years, the youngest being 8 and the oldest 18 years. All the remaining children of this group remained free from clinical tuberculosis throughout the period of observation.

Various methods of finding clinical cases of pulmonary tuberculosis were tried, but it is pointed out that the only entirely satisfactory method consists in testing all persons in a community with tuberculin, making x-ray films of the chests of the reactors periodically and examining those who have shadows to determine the cause of their disease.

Since the first infection type of tuberculosis does not confer dependable immunity, as does an attack of smallpox, attempts to produce immunity by other methods are based on a shaky premise and do not appear to be the proper approach to the solution of the problem. The only known satisfactory method of preventing tuberculosis in the human body consists in creating an environment free from tubercle bacilli.

This volume has added much valuable information to the literature of tuberculosis and should be read by all physicians interested in the diagnosis, treatment and prevention of the disease.

Reaction to Injury: Pathology for Students of Disease Based on the Functional and Morphological Responses of Tissues to Injurious Agents. By Wiley D. Forbus, M.D., Professor of Pathology, Duke University and Pathologist to the Duke Hospital, Durham, N. C. Cloth. Price, $9. Pp. 797, with 532 illustrations. Baltimore: Williams & Wilkins Company, 1943.

"In its present form this book is made up of two of the four parts called for in the original plan of the work. The two parts constitute a clearly defined entity, dealing with the nature and causation of disease and with the resistive reaction: the inflammatory process and all the infectious diseases that arise therefrom." Interest centers in the individual as a whole and the old, more conventional treatment of the subject as "special" pathology has been avoided. In the preface the author explains that in order to meet the needs of continuous education and to provide opportunity for cultivation of knowledge of the basic science of disease "a specific theme has been adopted, and the materials have been selected, arranged and dealt with in such a way that the theme is always evident—disease is a matter of the abnormal outcome of a constantly changing relation between the ultimate biological unit, the cell, and its environment."

Part one, approximately one sixth of this volume, is an introduction to the study of disease. The evolution of present day concepts of the nature of disease is presented in an interesting and stimulating fashion, so devised as to give the beginner an important and all too frequently neglected historical background. The etiology and pathogenesis of disease receive particular emphasis; especially notable is the elaborate classification and discussion of pathogenic agents of the plant and animal kingdoms. According to the author's plan "the individual is considered to be capable of reacting in only three essential ways, (1) by resisting, (2) by submitting and (3) by effecting an adaptation. These three reactions, therefore, are taken to be the basis of all disease, and the recognized disease entities are considered to be the expressions of the elaboration of one of several of these reactions."

Any general plan for the formal presentation of a subject as complex as pathology must represent some sort of compromise and thus be open to certain adverse criticism. The plan followed in this work is no exception. One of the most difficult and complex parts of pathology, the inflammatory reaction, is introduced at the beginning without the preparation that a detailed study of simpler reactions, e. g. hyperemia, hemorrhage, edema or various degenerative processes, would afford. Such sharp distinctions are made between the various "parts" of pathology in this work that the student is often presented with what must seem to him a fairly complete discussion of a disease, yet some very important complication or end result of the disease may not be included because it does not fit in with the particular phase of pathology being discussed. An example of this is found in the discussion of chronic osteomyelitis, in which no hint is given of the possibility of amyloidosis as a complicating factor. Similarly, for rheumatic heart disease there is practically no discussion of its most important sequel, the heart failure which often follows long after the acute inflammatory episode, due to cicatricial changes. In spite of the evident intention to emphasize general principles and mechanisms, the

result is not all that might be desired. Too often a comparatively brief discussion of general principles is followed by the presentation of numerous disease entities which seem to be rather detached from one another and but weakly connected with the important principles which they are supposed to illustrate. Of 646 pages concerning resistive reaction to injury it seems rather disproportionate to devote but two thirds of a page to metabolism and functions in inflamed tissues, two and one-half pages to the functional significance of the elements of the inflammatory exudate, and but one page to a general discussion of repair of tissues following the inflammatory reaction. It is difficult to criticize fairly half a work without knowledge of just what the other half contains. It does appear, however, that in a "completed treatment of resistive reaction to injury" cirrhosis of the liver and asthma, for example, should be considered and, furthermore, that some general statements should be made regarding the role that hyperplasia, metaplasia, hypertrophy, regeneration and fibroplasia may have in a resistive reaction to injury.

A major defect of this volume, and one which detracts especially from a new work, lies in the selection of reference material. For example, concerning such an active subject as rheumatic fever the average date of publication for the 70 references given lies between 1924 and 1925. Less than 10 per cent of these were published within the last ten years. Similarly for the subject of experimental nephritis the most recent of the 11 references is 13 years old, antedating one of the most important advances in this field: the production of glomerulonephritis with nephrotoxin. Heffron's monograph on the pathogenesis of lobar pneumonia is referred to twice, with the implication that this represents the last word on the subject. This work is 13 years old and does not include some of the important experimental data on which our present day concepts of this disease are based. Even in the field of virus diseases, where new knowledge is increasing rapidly, the most recent of 11 reference on general considerations of virus diseases is 7 years old.

Especially commendable in this book are the portions which deal with specific granulomatous diseases, and the large sections on virus and rickettsial diseases. There are numerous illustrations of exceptional quality from the standpoint both of technical excellence and of suitability. The material is well indexed except for an occasional rather important omission, e. g. hyperemia and rheumatic fever (listed as acute rheumatic fever). The text is well printed on paper of excellent quality and the volume is attractively and sturdily bound.

It is doubtful that this work will supplant the several excellent single volume textbooks of pathology now in use; however, it presents many exceptional features including a rather complete coverage of the acute inflammatory diseases. Part I provides an excellent introduction to the study of pathology and disease in general.

Small Community Hospitals. By Henry J. Southmayd, Director, Division of Rural Hospitals, The Commonwealth Fund, and Geddes Smith, Associate, The Commonwealth Fund. Cloth. Price, $2. Pp. 182. New York: Commonwealth Fund; London: Oxford University Press, 1944.

This is a book of importance to any one who wishes to establish a hospital of 50 beds or less. Its practical point of view will appeal to members of the medical profession and to leaders of the community who might be given some responsibility in the establishment of a small hospital. Many of the subjects discussed will apply to institutions having a larger bed capacity, but the reader is cautioned that all remarks cannot apply to hospitals having more than 50 beds. Larger institutions can expect to have the services of a qualified pathologist and a qualified radiologist to supervise the laboratories. Small institutions cannot afford adequate supervision but should nevertheless strive to maintain some professional supervision of these departments. Exception should be taken to the apparent reliance on recently graduated technicians of commercial training schools. Undoubtedly small, recently established hospitals would profit by obtaining the services of experienced technicians and preferably a technician who is registered by recognized organizations such as the Registry of Medical Technologists or the American Registry of X-Ray Technicians.

Common Skin Diseases. By A. C. Roxburgh, M.A., M.D., B.Ch., Physician in Charge of the Skin Department and Lecturer on Diseases of the Skin, St. Bartholomew's Hospital, London. Seventh edition. Fabrikoid. Price, 18s. Pp. 453, with 192 illustrations. London: H. K. Lewis & Co., Ltd., 1944.

This is the seventh edition of Roxburgh's book to appear since its first publication in 1932. That fact itself attests its value. Like the previous editions, it is a clearly written book designed for the general practitioner, with emphasis on the commoner diseases, their differential diagnosis and practical therapeutic procedures such as the practitioner is in a position to give. It is a book written from experience, rather than a compilation of abstracts from the literature, and written with a style that is readable, conversational and understandable. The type is large, the stock excellent and the photographic illustrations plentiful, large and clear. It does not pretend to be a complete treatise or reference work, yet it contains information about the newer things, as the vitamins, sulfonamides, penicillin, the influence of war on certain dermatoses and industrial dermatitis. Emphasis throughout the book is placed on the broader conception of dermatology rather than on minutiae. Within its scope it is an excellent book that fully deserves recommendation.

The War and Mental Health in England. By James M. Mackintosh, M.D., Professor of Preventive Medicine, University of Glasgow. Cloth. Price, 85 cents. Pp. 91. New York: Commonwealth Fund; London: Oxford University Press, 1944.

This monograph includes two parts. The first part contains chapters on the process of adjustment, the lonely year 1940-1941, defense, preparation and alliance 1941-1942 and the end of the beginning 1942-1943. The second part contains chapters on hospital services, voluntary organizations for mental health, professional education in mental health and some problems of the future. The author discusses the psychodynamics of normal thinking and abnormal thinking as well as many other mental aberrations deftly, simply and accurately. His proposal to educate every one regarding proper, normal and clear thinking is commended. When the war is over people must begin to busy themselves with the vocations, jobs and responsibilities they had before. When mental disease develops it must be treated as is any other disease, as quickly as possible. Education in regard to mental health according to the author should begin early in life and be continued throughout life. There are myriads of excellent ideas in this small publication.

Poliomyelitis: The Relation of Neurotropic Streptococci to Epidemic and Experimental Poliomyelitis and Poliomyelitis Virus, Diagnostic Serologic Tests and Serum Treatment. By Edward C. Rosenow, M.D., Professor of Experimental Bacteriology, University of Minnesota, Mayo Foundation, Rochester. Vol. A44 The International Bulletin for Medical Research and Public Hygiene. W. L. Colze, Editor-in-Chief. Paper. Pp. 87, with 26 illustrations. New York, Brussels & London: International Bulletin, [1944].

The author summarizes his researches over many years on the problems indicated by the title. No new evidence is presented in support of his well known views with regard to the causation of poliomyelitis, but he gives a comprehensive, painstaking and helpful account with full references of the many experiments and observations previously reported in medical journals. His hope is that the monograph "will meet the objections that have stood in the way of a general acceptance of the primary streptococcal causation of poliomyelitis and the streptococcal source of the virus."

Healthful Living for Nurses. By Harold S. Diehl, M.S., M.D., Sc.D., Professor of Preventive Medicine and Public Health and Dean of the Medical Sciences, University of Minnesota, Minneapolis, and Ruth E. Boynton, M.S., M.D., Professor of Preventive Medicine and Public Health and Director of the Student's Health Service, University of Minnesota. Cloth. Price, $2.50. Pp. 534, with 34 illustrations. New York & London: McGraw-Hill Book Company, Inc., 1944.

This textbook on healthful living for nurses is complete, authentic and readable. It is amply documented, the references being given chapter by chapter, together with discussion suggestions. It is organized as a textbook for the obvious purpose of being used in nurses' training schools. As such, it should be of the greatest usefulness. It is liberally illustrated with charts, diagrams and drawings. It can be recommended without reservation.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

CLOTTING OF MENSTRUAL BLOOD—SIGNS OF FETAL DISTRESS DURING LABOR

To the Editor:—What pathologic or physiologic changes occur in the menstrual blood when clots form? In the normal woman one does not expect to find clots. I realize that fibroid tumors and other glandular disturbances may produce clots, but I should like to know why this occurs. If meconium appears in the vaginal discharge of a patient who is having a normal labor and the fetal heart rate becomes rapid, changing from 140 to 170, what would one expect as the cause and what can be done? Such a patient was examined rectally; there was dilatation of about two fingerbreadths, there was no evidence of cord prolapse and the patient was in good condition. At this time she was given a hypodermic of vitamin K but the baby died a few hours after birth and at the time of birth showed asphyxia. I have often seen meconium stained amniotic fluid when the baby would be perfectly normal. Are there any precautions or any special procedures that should be taken when meconium stained fluid appears during the course of labor before the cervix is dilated?

M.D., Washington.

ANSWER.—Under normal conditions menstrual blood does not clot, because in passing through the endometrium it undergoes certain changes which tend to inhibit coagulation. The nature of these changes is obscure, but presumably some anticoagulant substance is added or some ingredient of the blood necessary for clotting is removed. Since blood obtained from a needle prick of the cervix does clot, it is clear that the anticoagulant mechanism resides in the endometrium. While this mechanism is adequate for the usual quantity of menstrual bleeding, it may be unable to cope with excessive hemorrhage, and under these circumstances clots develop. As a rule, therefore, clot formation in the menstrual discharge means a more rapid escape of blood from the endometrium than is normal.

The two most dependable signs of fetal distress in labor are a slow fetal heart rate (under 90) and irregularity. A rapid rate (170 and above) and meconium stained amniotic fluid are less trustworthy signs and may be present in cases in which the fetus is entirely normal. Accordingly, the latter two signs should not be regarded as indications for immediate delivery unless the cervix is fully dilated with the head on the perineum. If the cervix is not fully dilated the best results will be obtained in the long run if labor is allowed to continue. Indeed, operative intervention prior to complete dilatation is rarely justified even if unequivocal signs of fetal distress occur, because (1) the trauma imposed on the baby by such an operation often does more harm than the continuation of labor and (2) it is not right to jeopardize the mother's outlook by a traumatic operation for the sake of an infant whose chances of survival are already dubious. The administration of oxygen to the mother in such cases may be helpful. A rapid fetal heart rate is presumably the result of a temporary vagal paralysis, but the causes which bring about the latter condition are not definitely known.

AGGLUTINATION OF TYPHOID-PARATYPHOID AND DYSENTERY ORGANISMS

To the Editor:—What is the significance of a positive serum agglutination test for paradysentery A in a titer of 1:320 in a patient who had a severe attack of diarrhea lasting forty-eight hours four months before? Could a recent immunization against typhoid and paratyphoid produce agglutinins against paradysentery organisms?

M.D., South Carolina.

ANSWER.—It is assumed that the Flexner bacillus, Shigella paradysenteriae, is meant by paradysentery A. Though normal human serum frequently agglutinates this organism to a high titer, often 1:150 and sometimes higher, a titer of 1:320 in the absence of agglutinins for Shiga's bacillus is suggestive of infection. The agglutinin titer usually drops rapidly after recovery, and its persistence for as long as four months might be taken to suggest a carrier state. However, the significance of the presence of agglutinins for dysentery bacilli, and the Flexner bacillus in particular, is questionable and should be interpreted with caution; the only completely satisfactory diagnostic test is the isolation of the bacillus from the feces.

A recent typhoid-paratyphoid immunization might produce an anamnestic rise in dysentery agglutinins but probably not to the observed titer. Though a number of strains of the Y type of Flexner's bacillus have been found to contain Salmonella antigens VI and XIII (Bornstein, Siegbert; Saphra, I., and Daniels, J. B.: *J. Immunol.* **42**:401 [Dec.] 1941) the occurrence in dysentery bacilli of antigens present in the typhoid bacillus and the paratyphoid A and paratyphoid B bacilli has not as yet been observed.

NEURITIS PROBABLY FROM IODIZED POPPY SEED OIL IN SPINAL CANAL

To the Editor:—Five cc. of iodized poppy seed oil was injected intrathecally and cisternally because of pain, hyperesthesia and anesthesia along the course of the 6th cervical dorsal nerve roots C_6 through C_8 on the right, with generalized weakness of the right arm. For twenty-four hours following there was severe headache, general malaise and a temperature of 102. For two weeks the patient could not lie flat because of pain in the lumbar and sacral regions. This disappeared to be followed by coccygeal neuritic pain on sneezing or on laughing heartily. Three months after injection there were severe neuritic pains in the right sacroiliac region, right hip and right posterior thigh, coming on after standing or walking and relieved by lying down. Are the pains due to the injection? Should an attempt be made now after almost four months to remove the oil? How is that done? The patient is a 35 year old man.

M.D., Rhode Island.

ANSWER.—One would have to consider the possibility of a protruded cervical disk in this patient. It is rather unusual to have a unilateral neuritis.

The coccygeal neuritic pain produced on sneezing and laughing following the injection of iodized oil suggests that the patient has probably developed some neuritis as the result of the oil. The removal of the oil is probably advisable. However, before this is done another fluoroscopy should be made with the oil of the lumbosacral area and of the cervical area either to verify or to disprove the presence of protruded disks in both locations. Following this, the iodized oil should be removed with a spinal puncture needle placed in the fourth lumbar space according to Kubik and Hampson's technic (Removal of Iodized Oil by Lumbar Puncture, *New England J. Med.* **224**:455 [March 13] 1941), which consists in adjusting the table so that the volume of oil is placed about the tip of the spinal puncture needle, at which time gentle suctions with the use of a syringe should effect a thorough removal. It is true that the last remaining drops of oil have to be recentered about the needle in order to remove it thoroughly. The centering of the oil about the needle is done with the aid of the fluoroscope.

IMPAIRED HEARING FROM ACOUSTIC TRAUMA

To the Editor:—A man aged 38 who claims no previous trouble with his hearing developed bilateral total deafness while working as a chipper in a shipyard. His Wassermann reaction is negative. A change of position has not improved his hearing. A neurologist states that there is no neurologic basis for his loss of hearing and that it is not psychogenic. His ear drums are normal. If chipping noises are the cause of his deafness, what is the pathogenesis? Would this be considered as an accident or an occupational disease?

J. Douglas Barry, M.D., Wilmington, Del.

ANSWER.—Impaired hearing from acoustic trauma is characterized either by a slowly progressive hearing loss beginning for the tone of 4,096 vibrations or, if there has been a sudden loud sound close to the ear, there may be an acute onset of a hearing loss. It would seem unlikely that a bilateral total deafness such as described could be the result of acoustic trauma and could be classed as occupational. The pathogenesis of deafness from acoustic trauma is an initial fatigue of the auditory nerve followed by progressive degeneration as the exposure continues.

JUNGLE ROT

To the Editor:—Will you kindly send me all the information you have on the treatment, prognosis and pathology of a disease known as jungle rot? Will you tell me something about the etiology and contagiousness of the disease?

M.D., California.

ANSWER.—The United States Army Medical Department has no information concerning the disease called "jungle rot." Perhaps the term applies to a condition known as "Barcoo rot," which is a synonym for "desert sore" or "veld sore." References to this condition may be found on page 1107 of Stitt's "Diagnosis, Prevention and Treatment of Tropical Diseases" by R. P. Strong and on page 679 of the eleventh edition of "Manson's Tropical Diseases" by Philip Manson-Bahr.

From Panama comes information that the terms "jungle rot" and "tropical rot" are used by laymen to describe any sort of sore developing on the body, usually a severe form of mycotic fungus, mold or yeast infection.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, MAY-AUGUST 1944

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1933. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta Radiologica. Stockholm.
Actas Dermo-Sifiliograficas. Madrid.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Cincinnati.
American Journal of Orthopsychiatry. New York.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
American Review of Soviet Medicine. New York.
American Review of Tuberculosis. New York.
Anales de la Cátedra de patología y clínica de la tuberculosis. Buenos Aires.
Anales del Dispensario Público nacional para Enfermedades del Aparato Digestivo. Buenos Aires.
Anesthesiology. New York.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
*Archives of Dermatology and Syphilology. A. M. A., Chicago.
Archives of Disease in Childhood. London.
*Archives of Internal Medicine. A. M. A., Chicago.
*Archives of Neurology and Psychiatry. A. M. A., Chicago.
*Archives of Ophthalmology. A. M. A., Chicago.
*Archives of Otolaryngology. A. M. A., Chicago.
*Archives of Pathology. A. M. A., Chicago.
Archives of Physical Therapy. Chicago.
*Archives of Surgery. A. M. A., Chicago.
Archivos de Pediatría del Uruguay. Montevideo.
Arizona Medicine. Phoenix.
Australian and New Zealand Journal Surgery. Sydney.
Boletin del Instituto de Maternidad. Buenos Aires.
Boletin de la Sociedad Cubana de Pediatría. Havana.
Bollettino Della Societa Italiana di Medicina e Igiene Tropicale. Asmara.
Brain. London.
British Heart Journal. London.
British Journal of Children's Diseases. Dorking, England.
British Journal of Dermatology and Syphilis. London.
British Journal of Experimental Pathology. London.
British Journal of Ophthalmology. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Urology. London.
British Journal of Venereal Diseases. London.
British Medical Journal. London.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the New York Academy of Medicine. New York.
Bulletin of the U. S. Army Medical Department. Washington, D.
California and Western Medicine. San Francisco.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer Research. Baltimore.
Connecticut State Medical Journal. Hartford.
Delaware State Medical Journal. Wilmington.
Diseases of Chest. Chicago.
Edinburgh Medical Journal.
Endocrinology. Springfield, Ill.
Experimental Medicine and Surgery. Brooklyn.
Gastroenterology. Baltimore.
Hawaii Medical Journal. Honolulu.
Helvetica medica acta. Basel.
Illinois Medical Journal. Chicago.
Journal of Allergy. St. Louis.
Journal of the Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal of Bone and Joint Surgery. Boston.
Journal of Clinical Endocrinology. Springfield, Ill.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Industrial Hygiene and Toxicology. Baltimore.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Kansas Medical Society. Topeka.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal-Lancet. Minneapolis.
Journal of the Maine Medical Association. Portland.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of the Michigan State Medical Society. Lansing.
Journal of the Missouri State Medical Association. St. Louis.
Journal of the Mount Sinai Hospital. New York.
Journal of the National Cancer Institute. Washington, D. C.
Journal National Malaria Society. Tallahassee, Fla.
Journal of Nervous and Mental Disease. New York.
Journal of Neuropathology and Experimental Neurology. Baltimore.
Journal of Neurophysiology. Springfield, Ill.
Journal of Neurosurgery. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of British Empire. Manchester.
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Oral Surgery. Chicago.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of Physiology. Cambridge.
Journal of Royal Army Medical Corps. London.
Journal of Royal Naval Medical Service. London.
Journal of the South Carolina Medical Association. Florence.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Urology. Baltimore.
Kentucky Medical Journal. Bowling Green.
Klinische Wochenschrift. Berlin.
Lancet. London.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina. Madrid.
Medicine. Baltimore.
Medizinische Klinik. Berlin.
Military Surgeon. Washington, D. C.
Minnesota Medicine. St. Paul.
Münchener medizinische Wochenschrift. Munich.
Nebraska State Medical Journal. Lincoln.
New England Journal of Medicine. Boston.
New Orleans Medical and Surgical Journal.
New York State Journal of Medicine. New York.
North Carolina Medical Journal. Winston-Salem.
Northwest Medicine. Seattle.
Obstetricia y Ginecologia Latino-Americanas. Buenos Aires.
Ohio State Medical Journal. Columbus.
Pediatria e Puericultura. Bahia.
Pennsylvania Medical Journal. Harrisburg.
Physiological Reviews. Baltimore.
Practitioner. London.
Praxis. Bern.
Prensa Médica Argentina. Buenos Aires.
Psychosomatic Medicine. Baltimore.
Public Health Reports. Washington, D. C.
Puerto Rico J. Public Health & Tropical Medicine. San Juan.

*Cannot be lent.

Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Review of Gastroenterology. New York.
Revista de la Asociación Médica Argentina. Buenos Aires.
Revista Chilena de Pediatría. Santiago.
Revista clínica española. Madrid.
Revista Médica de Rosario. Rosario.
Revista de la Policlínica Caracas. Caracas.
Rhode Island Medical Journal. Providence.
Rocky Mountain Medical Journal. Denver.
Schweizerische medizinische Wochenschrift. Basel.
Semana médica. Buenos Aires.
South African Medical Journal. Cape Town.
Southern Medical Journal. Birmingham, Ala.
Surgery. St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Texas State Journal of Medicine. Fort Worth.
Transactions of the Royal Society of Tropical Medicine and Hygiene. London.
Union Médicale du Canada. Montreal.
United States Naval Medical Bulletin. Washington, D. C.
Virginia Medical Monthly. Richmond.
*War Medicine. A. M. A., Chicago.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
West Virginia Medical Journal. Charleston.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Am.—American	*Nat.—National*
A.—Association	*Pharm.—Pharmaceutical*
Coll.—College	*Phys.—Physicians*
Conf.—Conference	*Rev.—Revision*
Cong.—Congress	*Ry.—Railways*
Conv.—Convention	*Soc.—Society*
Dist.—District	*Surg.—Surgery*
Hosp.—Hospital	*Surgs.—Surgeons*
Internat.—International	*S.—Surgical*
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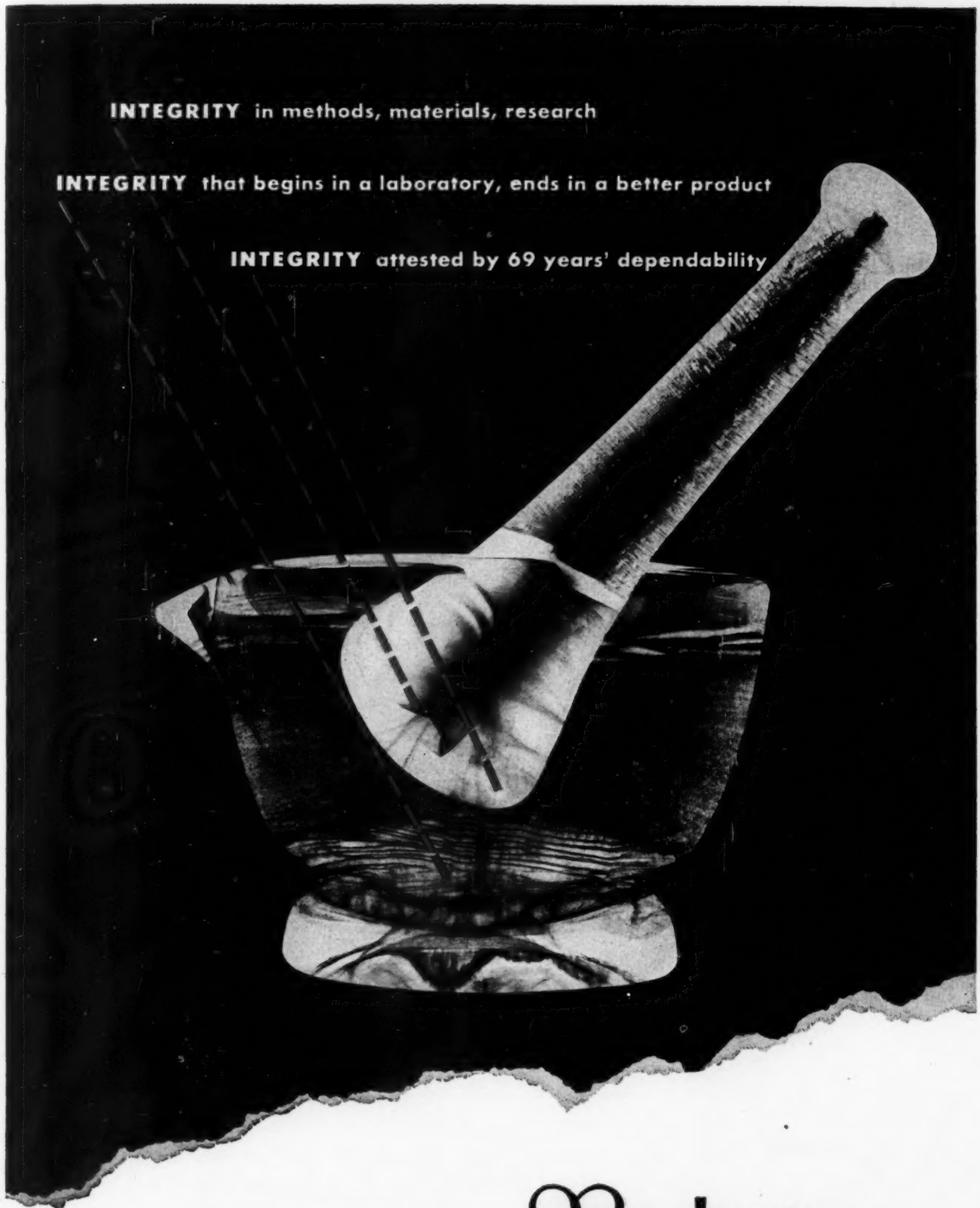
93— 178	2	May 13
179— 238	3	May 20
239— 320	4	May 27
321— 390	5	June 3
392— 460	6	June 10
461— 526	7	June 17
527— 602	8	June 24
603— 684	9	July 1
685— 760	10	July 8
761— 820	11	July 15
821— 880	12	July 22
881— 942	13	July 29
943—1002	14	Aug. 5
1003—1074	15	Aug. 12
1075—1162	16	Aug. 19
1163—1266	17	Aug. 26

INTEGRITY in methods, materials, research

INTEGRITY that begins in a laboratory, ends in a better product

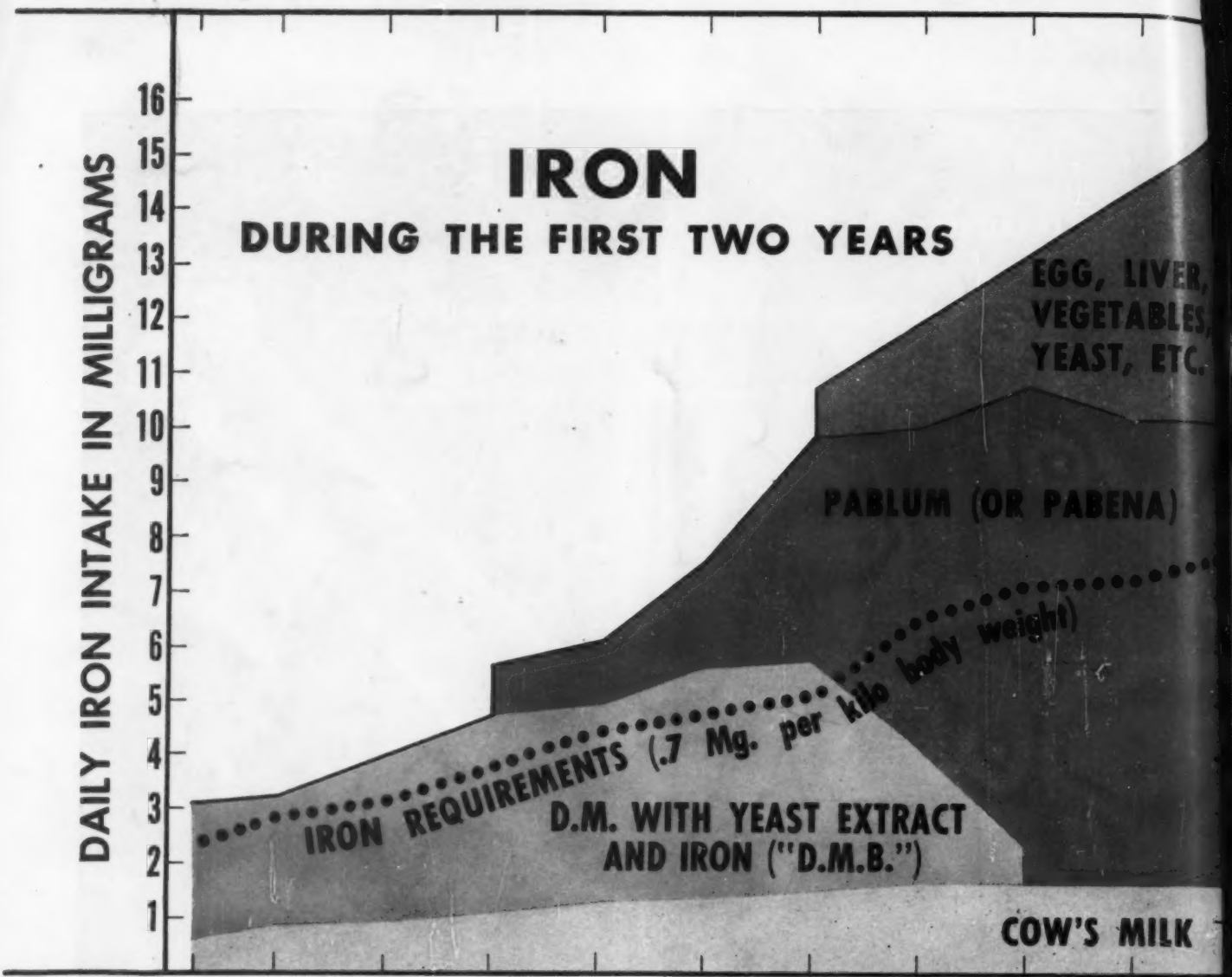
INTEGRITY attested by 69 years' dependability



• Integrity . . . a quality which has characterized the Maltine Company for nearly three-quarters of a century, is typified by the reputation of Maltine With Cod Liver Oil . . . a preparation prescribed today with the same confidence as was accorded it by physicians three generations ago.

Maltine

NEW YORK Established 1875



AGE, Mos.	¼	1	2	3	4	5	6	9	12	18
WEIGHT, Lbs.	7	9	10	12	14	15	16	19	22	23
MILK, Oz.	10	16	18	21	24	26	28	32	32	32
"D.M.B.," Oz.	1	1	1¼	1½	1½	1¾	1¾	1	¼	0
PABLUM, Oz.	0	0	0	⅛	¼	¼	½	¾	1	1

IRON DURING THE FIRST TWO YEARS

During fetal life iron accumulates (in the form of hemoglobin) in the infant's body. After birth the hemoglobin frequently drops to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. This chart shows that when the carbohydrate is "D.M.B." and the cereal is either Pablum or Pabena, a sizeable margin of safety over the requirements can be maintained, not only during the important first six months, but throughout the first two years of life.

More iron than the calculated requirement is needed because some iron is not utilized. In rapidly growing or poorly nourished infants, and in the presence of infection, the need for iron may be even greater than is indicated in this chart for normal infants.